Exhibit 2

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Re: ***United States v. Robert Sylvester Kelly, et al.,* No. 19 CR 567**

Dear Counsel:

The government submits this supplemental expert disclosure for Dr. Darrel Turner, pursuant to Federal Rule of Criminal Procedure 16(a)(1)(G).

Background and Qualifications

Dr. Darrel Turner has spent approximately 18 years in the field of clinical psychology. As described in his curriculum vitae, Dr. Turner has extensive experience conducting forensic and trial evaluations of adults and juveniles. In his private clinical practice, Dr. Turner has treated hundreds of victims of sexual abuse. Dr. Turner is one of fifteen Experts in Offender Psychology appointed to the U.S. Department of Justice National Strategy SME Child Exploitation and Human Trafficking Council to U.S. Congress. Dr. Turner regularly presents on topics related to child exploitation, including the grooming process. For example, Dr. Turner is scheduled to present at the internationally recognized Crimes Against Children Conference in Dallas, Texas, during the week of August 8, 2022. Specifically, Dr. Turner will be giving presentations about grooming and detecting deception among

child molesters. Dr. Turner has also presented on his peer-reviewed publication, "Grooming and Other Offense-Related Behaviors in Child Molestation Cases: An Analysis of Offender Self-Reported Behaviors and Beliefs." *See* Exhibit A.

Dr. Turner has been qualified as a clinical and forensic psychology expert in numerous court cases, including over a dozen federal criminal cases. *See* Case List, attached as Exhibit B. For example, a transcript of Dr. Turner's testimony in *United States v. Telles*, Case No. 16 CR 424 (N.D. Cal. 2019), an online enticement and international child sex traveler case, was provided to you with the government's expert disclosure dated July 1, 2022. The Ninth Circuit affirmed the conviction in that case and upheld Dr. Turner's testimony on the topics of grooming and victims' delayed disclosure of abuse. *See United States v. Telles*, 18 F.4th 290, 302-03 (9th Cir. 2021). Additional transcripts of Dr. Turner's testimony in child exploitation cases are enclosed with this supplemental disclosure, including:

- *United States v. Ebert*, Case No. 19 CR 244 (W.D.N.C. 2020) (Exhibit C)
- *United States v. Disney*, Case No. 12 CR 287 (E.D. Pa. 2013) (Exhibit D)
- *United States. v. Gillis*, Case No. 15 CR 226 (M.D. Fla. 2016) (offender risk assessment) (Exhibit E)

Expected Testimony

Dr. Turner will present general expert testimony on the topics listed in the government's disclosure dated July 1, 2022. These topics fall into two main categories: (1) the grooming behavior of sex offenders against children; and (2) delayed/partial disclosures by victims. Dr. Turner's opinions are based on his training, experience, and research, as detailed in his curriculum vitae. Dr. Turner has not reviewed any case-specific materials for this case and has not been provided with any facts specific to the offender or victims in this case, other than the names of the defendants.

Specifically, Dr. Turner is expected to testify about the following:

The process of grooming

Grooming in the context of child molestation by adults is the process by which offenders isolate intended victims, gradually introduce sexual themes and behaviors to systematically desensitize victims to the introduction of sex into the relationship, and prevent victims from disclosing.

Various specific behaviors have been identified by researchers and scholars as grooming by adult offenders, such as identifying or targeting specific children, giving gifts, giving compliments, special treatment or special activities, engaging in peer-like environments and sexual desensitizing, isolation, placing the responsibility on

the child, secrecy, and favoritism. Grooming is directly intended to facilitate access to the victim, however, the process also serves to manipulate family members of potential victims and individuals in the victim's social network, in order to facilitate abuse.

The offender isolates the victim in an effort to destroy the victim's frame of reference. The offender then becomes the frame of reference for the victim. Once the offender has isolated the victim, the offender often gradually introduces sexual themes, which may include jokes, references to pornography, other sexual images or references, so that the victim slowly becomes adjusted to sexual acts being a part of the relationship. This is the process by which an offender "normalizes" sexual acts with the child victim.

Research shows that grooming establishes an emotional connection, establishing trust and rapport between the offender and the victim. The offender uses the grooming process to pick up on insecurities and vulnerabilities of the victim and then uses these to develop trust and dependency. Offenders typically demonstrate antisocial behaviors that enable them to act as master manipulators of insecure and vulnerable victims. Offenders will often target victims who are disenchanted with home-life and life circumstances, display insecurities or depression, and are therefore easier to manipulate and control.

The grooming process can also involve gifts (according to one study, 43% of offenders report using gifts), but these gifts are often tied to the emotional connection with the victim and can reinforce this relationship on multiple levels.

Isolation often causes the child victim to feel complicit in the activities, including the abuse, and very often leads the victim to feel an emotional connection with the offender. These very by-products of the grooming phase are a direct cause of delayed or non-disclosure of child sexual abuse.

Delayed disclosure

The process of grooming develops a strong emotional connection between the offender and the victim. In one study, 46% of victims reported being in love with or feeling a close friendship with the offender.

Because the grooming process has established trust and an emotional connection, the victim has already been taught not to disclose. The victim may be afraid of getting in trouble. The offender has groomed the victim away from their family and authority figures who would be the figures they would disclose to.

Of those victims who do disclose their sexual abuse, a significant number don't disclose until adulthood. Over half of victims wait at least three years to disclose fully.

A very small percentage of sexual abuse crimes are reported; a very small percentage of all sexual abuse crimes result in criminal convictions. Victims will often defend the offender. Partial disclosure of the abuse is also a common result after a victim has been groomed by an offender. The victim will often test how adults react to partial details of the abuse to see whether it is safe to tell all of the details.

In support of his opinions, Dr. Turner will reference his own clinical experience, research, and expertise. He will also reference findings from some of the following studies:

- Akdeniz, Y. (2009). Internet Child Pornography and the Law: National and International Responses. Surrey: Ashgate Publishing.
- Beauregard, E., Proulx, J., Rossmo, D.K., Leclerc, B., & Allaire, J.F. (2007). A script analysis of patterns in the hunting process of serial sex offenders. Criminal Justice and Behavior, 34, 1069-1084.
- Bennett, N., & O'Donohue, W. (2014). The construct of grooming in child sexual abuse: conceptual and measurement issues. Journal Of Child Sexual Abuse, 23(8), 957-976. doi:10.1080/10538712.2014.960632.
- Black, P. J., Wollis, M., Woodworth, M., & Hancock, J. T. (2015). Research article: A linguistic analysis of grooming strategies of online child sex offenders: Implications for our understanding of predatory sexual behavior in an increasingly computer-mediated world. Child Abuse & Neglect, 44140-149. doi:10.1016/j.chiabu.2014.12.004.
- Brackenridge, C. H. (2001). Spoilsports: Understanding and preventing sexual exploitation in sports. London, England: Routledge.
- Christiansen, J. R., & Blake, R. H. (1990). The grooming process in father-daughter incest. In A. L. Horn (Ed.) The incest perpetrator: A family member no one wants to treat (pp. 88 – 98). Thousand Oaks, CA: Sage.
- Craven, S., Brown, S., & Gilchrist, E. (2006). Sexual grooming of children: Review of literature and theoretical considerations." Journal of Sexual Aggression, 12, 287-299.
- Elliott, I. A. (2017). A Self-Regulation Model of Sexual Grooming. Trauma, Violence, & Abuse, 18, 83-97.
- Elliott, M., Browne, K., & Kilcoyne, J. (1995). Child sexual abuse prevention: What offenders tell us. Child Abuse and Neglect, 19, 579-594.
- European Online Grooming Project: Webster, S., Davidson, J. Bifulco, A., Gottschalk, P., Caretti, V., Pham, T., Grove-Hills, J., Turley, C., Tompkins, C., Ciulla, S., Milazzo, V., Schimmenti, A., & Craparo, G. 2012. European Online Grooming Project Final Report. European Union. Retrieved April 21, 2012 (http://www.european-online-grooming-project.com/).
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- Hanson, R. K. & Morton-Bourgon, K. E. (2005). The characteristics of persistent sexual offenders: A meta-analysis of recidivism studies. Journal of

Consulting and Clinical Psychology, 73, 1154-1163. doi: 10.1037/0022-006X.73.6.1154.

- Hare, R. D. (2003). Hare PCL-R, 2nd edition. New York: Multi-Health Systems.
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- Kaufman, K.L., Hilliker, D.R., & Daleiden, E.L. (1996). Subgroup differences in the modus operandi of adolescent sexual offenders. Child Maltreatment, 1, 17-24.
- Leberg, E. (1997). Understanding child molesters: Taking charge. Thousand Oaks, CA: Sage.
- McAlinden, A.M. (2006). 'Setting 'em up'. Personal, familial, and institutional grooming in the sexual abuse of children. Social and Legal Studies, 15, 339-362.
- McElvaney, R. (2015). Disclosure of child sexual abuse: Delays, non-disclosure, and partial disclosure. What the research tells us and implications for practice. Child Abuse Review, 24, 159-169.
- Moors, R., & Webber, R. (2012). The dance of disclosure: Online self-disclosure of sexual assault. Qualitative Social Work, 12, 799-815.
- O'Connell, R. (2003). A typology of cyber sexploitation and online grooming practices. Preston, England: University of Central Lancashire. Retrieved from http://www.uclan.ac.uk/host/cru/docs/cru010.pdf
- Olson, L.N., Daggs, J.L., Ellevoild, B.L., & Rogers, T.K. (2007). Entrapping the innocent: Toward a theory of child sexual predators' luring communication. Communication Theory, 17, 231-251.
- Ospina, M., Harstall, C., & Dennet, L. (2010). "Sexual exploitation of children and youth over the internet: A rapid review of the scientific literature." Retrieved May 2, 2012 (http://www.ihe.ca/documents/Online%20Sexual %20Exploitation.pdf).
- Ost, S. (2009). Child Pornography and Sexual Grooming: Legal and Societal Responses. Cambridge: Cambridge University Press.
- Proeve, M., & Howells, K. (2002). "Shame and guilt in child sexual offenders." International Journal of Offender Therapy and Comparative Criminology, 46, 657-667.
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- Smallbone, S., & Wortley, R. (2000). Child sexual abuse in Queensland: Offender characteristics and modus operandi: Full report. Brisbane, Australia: Queensland Crime Commission.
- Sullivan, J., & Beech (2004). A comparative study of demographic data relating to intra- and extra-familial child sexual abusers and professional perpetrators. Journal of Sexual Aggression, 10, 39-50.

- van Dam, C. (2001). Identifying child molesters: Preventing child sexual abuse by recognizing the patterns of offenders. Binghamton, NY: The Haworth Press.
- Ward, T. (2000). Sexual offenders' cognitive distortions as implicit theories." Aggression and Violent Behavior, 5, 491-507.
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The below articles are also enclosed, for your reference.

- Somer, Variables in Delayed Disclosure of Childhood Sexual Abuse (Exhibit F)
- Hebert, Prevalence of Childhood Sexual Abuse and Timing of Disclosure in a Representative Sample of Adults from Quebec (Exhibit G)
- London, Disclosure of Child Sexual Abuse (Exhibit H)

Very truly yours,

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Exhibit A

Grooming and other Offense-Related Behaviors in Child Molestation Cases: An Analysis of Offender Self-Reported Behaviors and Beliefs

Abstract

Most scholars agree that adult offenders who perpetrate sexual abuse of children engage in preparatory grooming behaviors to facilitate this abuse. The current study explored this phenomenon from the perspective of child molesters - gathering information from sexual offenders about this constellation of behaviors and their attitudes and beliefs surrounding it. Adult first-time male sex offenders (N = 23) in a post-conviction outpatient treatment program with one or more child victims volunteered to participate in an anonymous study examining grooming behaviors. Participants engaged in a structured interview about specific grooming behaviors which also included a free-response portion in which offenders discussed their own grooming behaviors as well as their general thoughts on grooming in general. This portion also included the offender's thoughts on grooming as a construct (i.e., does it exist) and the qualitative difference between grooming a child for sexual purposes and pursuing a sexual relationship with a consenting adult (47.8% felt there was no difference between the two sets of behaviors). Data analysis also suggested five distinct indexes: the Grooming Index, Predatory Behavior Index, Efforts to Avoid Detection Index, Perpetuating Behavior Index, and Cognitive Distortion Index. Results are discussed in relation to applied field settings.

Keywords: sexual offender, grooming, child sexual abuse

Grooming and other Offense-Related Behaviors in Child Molestation Cases: An Analysis of Offender Self-Reported Behaviors and Beliefs

Grooming in the context of child molestation by adults is the process by which offenders isolate intended victims, gradually introduce sexual themes and behaviors to systematically desensitize victims to the introduction of sex into the relationship, and prevent victims from disclosing. Though many definitions have been proffered, these fundamental aspects are agreed upon by the majority of authors in the field (Whittle, 2015; Olson, Daggs, Ellevoid, & Rogers, 2007; McAlinden, 2006; Elliot, 2017; & Whittle, Hamilton-Giachritsis, & Beech, 2015). Some scholars do not, however, include disclosure prevention in their conceptualization of this construct (Williams, Elliott, & Beech, 2013). Regardless, this preparatory process has been acknowledged by most scholars in the field of adults who sexually offend against children (Beauregard, Proulx, Rossmo, Leclerc, & Allaire, 2007; Finkelhor, 1984; Kaufman, Hilliker, & Daleiden, 1996; Smallbone & Wortley, 2000; Wolf, 1984). Grooming is directly intended to facilitate access to the victim, however; the process also serves to manipulate family members of potential victims and individuals in the victim's social network in order to facilitate abuse as well (McAlinden, 2006; Craven, Brown, & Gilchrist, 2006). Grooming can involve physical, psychological, and social or community-based strategies to facilitate and perpetration of sexual abuse (Leberg, 1997). Various specific behaviors have been identified by researchers and scholars, such as identifying or targeting specific children (van Dam, 2001; Brackenridge, 2001), engaging in peer-like environments and sexual desensitizing (van Dam, 2001), tickling and bathing (Howitt, 1995; Bennett & O'Donohue, 2014), isolation (van Dam, 2001; Brackenridge, 2001; McAlinden, 2006; Whittle et. Al, 2015; Elliott, 2017), placing the responsibility on the

child (van Dam, 2001), secrecy (Brackenridge, 2001; Christiansen & Blake, 1990), and favoritism (Christiansen & Blake, 1990).

Most theoretical approaches to grooming suggest a stage or model process, whereby offenders engage in steps to facilitate the sexual abuse. A brief overview of one such stage theory, as developed by O'Connel (2003), follows. The first stage, known as the *Friendship Forming Stage,* involves the offender making contact with the targeted victim and establishing rapport, such as learning about likes and dislikes. This friendship is furthered in the next stage, the *Relationship Forming Stage,* whereby the offender discusses more personal constructs, such as family, friends, and social lives, and compassion is shown. The offender then engages in the *Risk Assessment Stage*, which involves more careful analysis of both the intended victim's behavior patterns and the likelihood of being caught. In the *Exclusivity Stage,* which follows, offenders make efforts to avoid detection through isolating the victim. This may also involve threats against the victim to guarantee secrecy, which could involve threats of violence, threats about the impact on the victim's family, or even threats about the potential loss of the relationship with the offender (Black et al., 2015). Lastly, the *Sexual Stage* takes place, during which the offender engages in sexualized behavior with the victim including viewing pornography, having sexualized conversations, and discussing the next step of a sexual relationship. Again, numerous models have been proposed which explain the process of grooming equally as thoroughly (McAlinden, 2006; Williams, Elliott, and Beech, 2013) to include Elliott's Self-Regulation Model of Sexual Grooming (2017), and Olson et. al's 2007 study examining Child Sexual Predators' luring communication patterns (2007).

However, although some have postulated definitions and mechanisms, no true consensus exists in the clinical, research, or forensic fields as to what grooming actually entails, making

description and adequate measurement nearly impossible. Bennet and O'Donohue (2014), rightly noting this, attempted to generate a uniform approach to defining it, synthesizing scholar definitions into a two part definition of grooming:"(a) the behavior being evaluated must in and of itself be inappropriate and a case for this inappropriateness must be made, and (b) a sound argument must be presented that the behavior or behaviors increases the likelihood of future sexual abuse" (p 969). They provide examples of behavior that meet their criteria, such as: sexualization of relationships, gift giving, inappropriate touching, isolation, favoritism, secrecy, boundary violations, and providing the child with substances (e.g., drugs and alcohol).

Research of grooming has increased in quantity over the last decade, with some works examining the consequences of legal and societal responses to grooming and the use of child pornography (Ost, 2009; Akdeniz, 2009). Additionally, a large body of work examines the quality of grooming in the context of the internet (Whittle, Hamilton-Giachritsis, Beech, 2014; Whittle, Hamilton-Giachritses, Beech, Collings, 2013; Whittle, Hamilton-Giachritsis, Beech, 2014; and Kloess, Hamilton-Giachritsis, & Beech, 2017). Among the most seminal of these works is the European Grooming Project report on online grooming (2012).

In the present study, we sought to further the growing understanding of grooming behaviors by conducting structured interviews of adult male sexual offenders who offended against children focusing on specific grooming and offense-related behaviors as well as their opinions about grooming in general. This allowed for examination of what offenders believe to constitute grooming behaviors, how these behaviors take place, and the context in which they emerge. Of particular interest was sexual offenders' perceptions about what does and does not constitute grooming, as we believe this can help inform clinical work, research, and forensic practice, including cause, effect, treatment, and prevention of sexual abuse. We foresee

information gained from this research being directly applicable in applied work, such as forensic psychology (i.e. risk assessment evaluations and treatment of sex offenders and their victims) and law enforcement (i.e. formulating interview approaches of suspects). In our opinion, informing the knowledge base about particular behaviors with information from the persons that engage in them is of particular benefit given that the "outside" view of these behaviors by those involved in such cases may not accurately represent the view held by those perpetrating. Such an understanding will, hopefully, facilitate communication with offenders by professionals in mental health or legal capacities.

Method

We conducted structured interviews with 23 first-time sexual offenders enrolled in a post-prison release group outpatient sexual offender treatment program. All offenders were adult males who had offended against at least one child and had been convicted. The treatment program is a condition of their supervised release (eg. parole, probation, deferred adjudication), and it is facilitated by Master's level Licensed Sex Offender Treatment Providers. Participants were compensated by being allowed to miss one homework assignment or one group meeting without sanction by the outpatient facility. A Licensed Clinical Forensic Psychologist conducted the interviews which each lasted approximately 45 minutes.

In addition, participants were guaranteed that the treatment providers at the outpatient clinic where they received treatment would neither ask researchers about participant responses nor would researchers discuss the offenders' responses with treatment clinic. Given the propensity of sex offenders to engage in positive impression management and tendency to be less than completely forthright about the extent of their abusive behaviors (Salter, 1988; Proeve &

Howells, 2002), this aspect of the study was important in the effort to obtain valid and accurate responses from the participants.

Materials and Procedure

Structured interview. Participants in our study underwent a structured interview to assess their beliefs and behaviors related to sexual offending behaviors and grooming. A Licensed Clinical Forensic Psychologist asked them specific questions pertaining to known grooming behaviors (eg., isolating the victim, giving gifts, showing special attention to the intended victim), as well as those related to predatory behavior, efforts to avoid detection, and behaviors that perpetuate or promote sexual dysregulation or offending. Participants were also asked general opinion questions about grooming (e.g., whether it is an actual phenomenon, whether it differs from an adult male pursuing an adult female for consensual sex), and open-ended questions about which grooming behaviors they perpetrated. Participants were also asked to discuss grooming behaviors in general in the open-ended portion of the interview, not necessarily specific behaviors in which they themselves had engaged. This line of questioning occurred regardless of whether they themselves believed they groomed their own victims. The offenders also provided information about their victims, their behavior during the offense (e.g., using substances during the offense), the presence of a personal sexual abuse history, the use of pornography either with victims or as a means of masturbatory fantasy, and basic demographic information.

Grooming Index. We created a Grooming Index, which was a sum of the items that tapped specific grooming behaviors that the sexual offenders were asked to endorse as either having engaged or not engaged in during the time period prior to their sexual offending with their victim(s) or immediately surrounding it. This Index included the following behaviors:

talking about sex with the victim, graduated touching, giving compliments, giving gifts, showing adult-only pornography to the victim, showing child-involved pornography to the victim, being nude in the home (without a sexual nature), making online contact, and consuming alcohol with the child victim.

Predatory Behavior Index. We created a Predatory Behavior Index, which was a sum of items that tapped specific predatory behaviors that sexual offenders were asked to endorse as engaging or not engaging in during the time period prior to their sexual offending with their victim(s) or immediately surrounding it. This Index included the following behaviors: targeting families with children, seeking employment with access to children, and isolating their victim away from others.

Efforts to Avoid Detection Index. We created an Efforts to Avoid Detection Index, which was a sum of items that tapped specific detection-avoiding behaviors. The sexual offenders were asked to indicate whether they did or did not engage in these behaviors during the time period prior to their sexual offending with their victim(s) or immediately surrounding it. This Index included the following behaviors: using physical violence, threatening physical violence, asking the victim not to tell others, telling the victim not to tell others, warning the victim of the impact disclosing would have on the victim's family, warning the victim that others would disbelieve the victim, and threatening the victim with the loss of his/her relationship with the offender.

Perpetuating Behavior Index. We created a Perpetuating Behavior Index, which was a sum of items that tapped specific behaviors that perpetuate or promote sexual dysregulation or offending that sexual offenders were asked to endorse as engaging or not engaging in during the time period prior to their sexual offending with their victim(s) or immediately surrounding it.

This Index included the following behaviors: viewing child pornography, masturbating to fantasies or actions similar to the perpetrator's offending, viewing pornography similar to the offense (eg. viewing pornography involving sex with a babysitter when the intended victim was working as a babysitter for the offender), and masturbating to memories of the abuse of the victim.

Cognitive Distortions Index. We created a Cognitive Distortions Index, which was a sum of items that tapped specific endorsement of items indicative of thinking errors supportive of offense behaviors. The offenders were asked to indicate yes or no agreement with two statements surrounding their victim(s): 1) feeling the victim(s) wanted the sexual contact, and 2) feeling the victim(s) initiated the sexual contact.

Free-Response Grooming Behavior Items. The sexual offenders were additionally asked two free-response questions related to grooming behaviors. The first required the offenders to describe grooming behaviors they participated in, while the second required offenders to describe grooming behaviors in general and what the process of grooming might entail. These free-response items were coded into categories based upon their free responses, resulting in 11 total categories: Complimenting, Giving Gifts, Special Activities, Special Treatment, Desensitization, Rapport, Trust, Manipulation, Rationalization, Access, and Other.

Opinion Questions. The participants were asked opinion questions about grooming. Specifically, they were asked to respond to whether they participated in grooming, if grooming actually existed and occurred in the community (i.e., was it a real construct), and if the types of behaviors used on children in grooming were the same types of behaviors used on adults in courting (i.e., is grooming children the same as "grooming" adults who are the object of sexual interest).

Results

The 23 male sexual offenders in our sample were, on average, 32.04 years old (*SD* = 10.12) at the time of their offense and 40.70 years old (*SD* = 12.80) at the time of the study. The majority (52.2%, *n* = 12) identified as Hispanic, 34.8% (*n* = 8) identified as Caucasian, two offenders identified as African American (8.7%), while one offender identified as Asian (4.3%). All had been convicted of at least one contact sexual offense against a minor, had received some sort of sanction through the court, and were currently in free society under some type of supervision and receiving mandatory sex offender treatment. The offenders had an average of 1.48 victims (*SD* = 1.16, range = 1 – 5). The average time between meeting their victim(s) and engaging in illegal sexual behavior ranged from 1 to 5,110 days/14 years (*M* = 997.12 days/2.73 years, *SD* = 1,477.24 days/ 4.05 years, Median = 365.00 days/1 year).

Grooming Index

The Grooming Index was composed of yes or no responses to the following eight behaviors: giving compliments (60.9%), graduated touching (52.2%), giving gifts (43.5%), talking about sex with the victim (34.8%), consuming alcohol with the child victim (30.4%). showing adult-only pornography to the victim (21.7%), %), making online contact (17.4%), being nude in the home (without a sexual nature; 13.0%), and showing child-involved pornography to the victim (4.3%). On average, the participants endorsed 2.78 behaviors (*SD* = 1.81, range = 0 – 6). The Total Grooming Index Score was positively correlated with the Total Predatory Behavior Score ($r = .45$, $p = .031$).

Predatory Behavior Index

The Predatory Behavior Index was composed of yes or no responses to the following three items: isolating their victim away from others (56.5%), targeting families with children

(4.3%), and seeking employment with access to children (4.3%). On average, the participants endorsed 0.65 behaviors (*SD* = 0.57, range = 0 – 2). The Predatory Behavior Index Score was positively correlated with the Grooming Index Score (described previously), as well as the Cognitive Distortions Index (r = .42, p = .044).

Efforts to Avoid Detection Index

The Efforts to Avoid Detection Index was composed of yes or no responses to the following six items: asking or telling the victim not to tell others (30.4%), using physical violence (17.4%), threatening the victim with the loss of his/her relationship with the offender (13.0%), threatening physical violence (4.3%), warning the victim of the impact disclosing would have on the victim's family (4.3%), and warning the victim that others would disbelieve the victim (4.3%). On average, the participants endorsed 0.74 behaviors (*SD* = 0.92, range = 0 – 3). The Predatory Behavior Index Score was positively correlated with the Cognitive Distortions Index (r = .45, p = .033).

Perpetuating Behavior Index

The Perpetuating Behavior Index was composed of yes or no responses to the following four items: masturbating to memories of the victim (17.4%), masturbating to fantasies or actions similar to the perpetrator's offending (8.7%), viewing child pornography (4.3%), and viewing pornography similar to the offense (4.3%). On average, the participants endorsed 0.35 behaviors (*SD* = 0.57, range = 0 – 2). The Perpetuating Behavior Index was not significantly related to any of the other Indexes.

Cognitive Distortions Index

The Cognitive Distortions Index was composed of yes or no responses to the following two items: feeling the victim(s) wanted the sexual contact (69.6%) and feeling the victim(s)

initiated the sexual contact (30.4%). On average, the participants endorsed 1.13 thoughts (*SD* = 0.76, range = 0 – 2). The Cognitive Distortions Index was significant correlated with the Efforts to Avoid Detection Index and the Predatory Behavior Index (both as previously described).

Free-Response Grooming Behavior Items

The offenders provided 132 free response answers to the two questions pertaining to the grooming behaviors in which they engaged and in what behaviors they constituted grooming in general. These answers could differ from the Index scores in that those were specific probes requiring yes/no answers while these grooming questions were asked prior to those. This allowed for un-cued answers and, thus, an untainted analysis of grooming behaviors in which these sexual offenders believed they may have been engaging. Table 1 presents the responses coded into 11 categories, based on deductive coding strategies, summarized by what the offenders believed to be their grooming behaviors in comparison to of what they believed grooming behaviors in general likely consisted. Offenders saw themselves as engaging more in categories such as Special Treatment and Desensitization and provided notably more Rationalizations than they attributed to occurring in grooming in general. They were more likely to attribute Giving Gifts, Rapport, Trust, and Manipulation as occurring during grooming but engaged in by themselves.

Opinion Questions

When asked whether they participated in grooming, only 43.5% affirmatively answered that they had engaged in grooming behaviors, although 87.0% agreed that grooming existed and occurred in the community (i.e., was it a real construct). Perhaps most interesting, 47.8% of the offenders stated that the types of behaviors used by adults on children during the grooming

process were no different than the types of behaviors adults use on adults in courting (i.e., "Is grooming children the same as "grooming" adults of sexual interest?").

Discussion

Overall, the sexual offenders in our sample perpetuated a wide array of grooming-related behaviors across a number of different domains. For instance, nearly 60% endorsed at least one item on the Grooming Index (giving compliments), while nearly 57% endorsed at least one item on the Predatory Behavior Index (isolating their victim). However, what we find to be most notable is that participants believe that grooming of intended child victims for sexual assault by an adult was no different from behaviors engaged in by an adult who is attempting to establish a sexual relationship with another consenting adult. Nearly half (47.8%) of participants indicate there was no difference between these two wholly opposite sexual behaviors. This finding, combined with the finding regarding the belief among participants that their child victims desired the sexual contact (69.6%) and the finding that nearly one third indicated that they felt the child victim(s) actually initiated the sexual contact, were among the most frequently endorsed items in the current study. These findings reflect the findings of Ward regarding victim blame among child molesters (2000). While it is not uncommon for offenders to engage in victim blame, these findings may be attributable to a "two-way street" of sexualization of children by pedophiles. That is, while pedophilic offenders are sexually attracted to children, they also attribute sexual desires, motivations, thoughts, and actions to children that non-pedophiles do not. If pedophilic offenders view children (at times) not as victims, but as willing sexual participants, then risk assessment evaluators, psychologists, psychiatrists, victim advocates, law enforcement, treatment providers, and other multidisciplinary team members involved in cases of sexual offenses against children may be well served to incorporate this understanding into their interactions with

offenders. It may be understandably difficult for non-pedophiles to accept this possibility and put themselves in a position to discuss the abuse with the offender in this context, yet it may provide an insight into the thinking and behavior of the offender that would not be accessible otherwise. It is also of note that the Cognitive Distortion Index contained the most frequent endorsement of its items – second only to the Grooming Index –, and offenders were most likely to attribute "rationalization" to themselves than they were any other free-response coded behavior (25.4%).

Another notable finding was that downward social comparison is also evident in the results of our study. Our participants, like many other offenders, view their offenses as being "not as bad" as "those other offenders." The offenders who engaged in digital fondling, for example, of a child view their behavior as being "not as bad" as an offender who engages in genital intercourse with a child. That offender who does engage in sexual intercourse with a child will not view his behaviors as being "as bad" as an offender who engages in violent coercion of his victim for sexual purposes. Initiating clinical contact with adults who sexually offend against children with this knowledge will aid the evaluator (detective, CPS worker) in establishing rapport for the purposes of gaining the most information from this offender. Offenders, though not asked to comment on "other" or "most" offenders, did tend to respond to questions about grooming in general in this manner. This phenomenon may inform potential alternatives to direct questioning of an offender when defense mechanisms are preventing progress in an interview or treatment session. A review of Table 1 reveals that the more openly manipulative behaviors associated with grooming are more often attributed to "other" offenders. For example, giving gifts, establishing trust, and manipulation are significantly more attributed to other offenders.

We also found that grooming also appears to be much more of an emotional construct than one involving actual tangible gifts, money, alcohol or drugs, etc. This finding is commensurate with previous research by Leberg (1997) and McClinden (2006) that address the emotional and psychological aspects of the grooming process. (The majority of free-response grooming behaviors as well as items endorsed during direct questioning are related to establishing an emotional relationship with the intended victim(s). For example, giving gifts (43.5%) or providing alcohol (30.4%) were the only grooming behaviors that involved tangible items as addressed in O'Connel 2003 study as well as others (Ospina, Harstall, & Dennet (2010); Whittle et al. 2013a). Other behaviors such as giving compliments (60.9%), and free response behaviors such as special activities, special treatment, desensitization, rapport, trust, and manipulation were endorsed with far more frequency. This finding likely reflects two phenomena, the first being that predators are aware of effective means with which to gain the trust and establish a relationship with their intended victim(s). The second aspect represented by this finding is that many pedophiles emotionally identify with children, a risk factor identified in the seminal Hanson et. al meta-analysis (2004), This second aspect includes engaging in activities most commonly enjoyed by children (i.e., frequenting certain child-themed establishments, playing, video games, frequenting locations often visited by children, etc.). This positioning of oneself in environments in which an offender has easy access to children is reflected in the research as well (Sullivan & Beech, 2004).

Importantly, nearly all of the above noted grooming activities involve isolating the intended victim. Isolating the victim as a direct question was endorsed by 56.5% of the participants and was among the most highly endorsed items in the entire study. Isolation of an intended victim serves to allow for the graduated introduction of sexual themes (i.e., through

graduated touching (52.2%), talking about sex with the victim (34.8%), showing adult-only pornography to the victim (21.7%), %), being nude in the home (without a sexual nature; (13.0%), entering into the relationship without a social frame of reference to inhibit the offender's ability to do so. Many of these themes (isolation, graduated introduction of sexual themes) have been discussed in theoretical discussions of grooming and were borne out in the current study (Craven et. al, 2006; Whittle et. al, 2015). In a sense, the offender, with enough isolation, *becomes* the victim's frame of reference, and is able to repeatedly reinforce the notion of sex between the child and adult as a "normal," "positive," and "universal" idea. This also serves, over the course of the abuse, to cause the child victim to feel complicit in the activities, including the abuse, and very often leads the victim to feel an emotional connection with the offender. These very by-products of the grooming phase are a direct cause of delayed or non-disclosure of child sexual abuse (Moors et. al, 2012; McElvaney, 2015). It is important to note that, in support of this notion, threatening the victim that he or she would lose the relationship with the perpetrator (13%) was among the three most frequently endorsed items in the Efforts to Avoid Detection Index, including asking or telling the victim not to tell others (30.4%), and using physical violence (17.4%). This means that, essentially, the grooming process creates such a perceived bond between the victim and the offender that an offender is able to continue to abuse the victim by threatening (in a less direct manner), "If you tell, I won't be able to abuse you like this anymore." This finding replicates a previous finding from a research study by Elliott et. al (1995).

Overall, the indexes established by the analysis of data are informative and revealing of offender behavior, and they are an effective manner in which to conceptualize the grooming process. While grooming behaviors will differ from one case to another, there are certain themes

common to grooming across cases, and understanding these themes can facilitate the overall understanding of sexual offending against children by adults and aid in the detection, evaluation, prosecution, and treatment of these offenders. It may also provide a framework with which layperson triers of fact may understand the complicated aspects of grooming, sexual assault of children, and the subsequent and often "counter-intuitive" behaviors of the victims that occur after the abuse and as a result of the grooming process (i.e., delayed disclosure, non-disclosure, seeming defensive of the offender, etc.).

Limitations and Future Directions

The sample in our study had two interrelated limitations. First, the sample size is relatively small, and, of course, more participants could have added to the robustness of the findings. Second, they were engaged in treatment, which would have impacted the amount of knowledge and insight they had about their grooming behaviors and grooming behaviors in general. However, we believe the strengths of our study far outweigh this limitation, and we believe that, given the lack of uniformity in answers, although they were all in the same treatment program, their responses obviously contained authenticity (as opposed to rote recollection of treatment concepts). We see future research building upon our free-response questions. Specifically, the purpose of the free-response portion of the interview was to allow offenders to provide their own description of the grooming process, as opposed to attempting to "box" offenders into a pre-conceived notion of what grooming involves by using pre-existing questionnaires or instruments designed by persons who study these behaviors but have not themselves engaged in them. A follow-up study that included data gleaned from the free-form responses in the direct question and answer portion may help provide even more data to assist in the understanding of what is, unfortunately, a growing problem in our society.

Conclusions

In this study, we asked sexual offenders about the practices they engage in related to grooming and their opinions about such practices. We found sexual offenders to provide valuable insight into the field's limited understanding of this complex system of behaviors. These results have direct field implications as they relate to apprehension, assessment, risk management, and treatment of sexual offenders, as well as research and theoretical importance.

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Table 1.

Percentage of Response to Grooming Behavior Items for Self-Perpetrated and Other-Perpetrated Opinions of Offenders

Type of Grooming Behavior	Self-Perpetrated (%)	Other-Perpetrated (%)
Complimenting	6.3	1.5
Giving Gifts	4.8	20.6
Special Activities	4.8	8.8
Special Treatment	12.7	5.9
Desensitization	17.5	7.4
Rapport	7.9	14.7
Trust	3.2	11.8
Manipulation	9.5	17.6
Rationalization	25.4	1.5
Access	3.2	4.4
Other	4.8	5.9

Exhibit B

DARREL B. TURNER, PhD – CASE LIST

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FEDERAL CASES

US v Damarcus Fitzhugh	Eastern District of Michigan	Defense – Evaluation/Consult
US v Syed Hussain	Eastern District of Michigan	Defense – Evaluation/Consult
US v Zachary Talamonti	Southern District of Indiana	Defense – Evaluation/Consult
US v Numann	District of Alaska	Evaluation/Consultation/Testimony
US v Hamrick	District of Nevada	Evaluation/Consultation
US v Wendell Eaves	Middle and Western Districts of Louisiana	Defense – Evaluation/Consult
US v Harold Anderson	Middle and Western Districts of Louisiana	Defense – Evaluation/Consult
US v Disney	Eastern District of Pennsylvania	Evaluation/Consultation/Testimony
US v Christopher Harling	District of Montana	Evaluation/Consultation
US v Dane Gillis	Middle District of Florida	Evaluation/Consultation/Testimony
US v Antonio Fontana	Eastern District of Michigan – Southern Division	Evaluation/Consultation
US v Brian Graco	Eastern District of Louisiana	Evaluation/Consultation/Testimony
US v Phillip Bradley Sanderson	District of Nevada	Evaluation/Consultation/Testimony
US v Moseley	Western District of Oklahoma	Evaluation/Consultation
US v Sam Elliott	District of New Mexico	Evaluation/Consultation/Testimony
US v Jose Zanabria	Western District of Oklahoma	Evaluation/Consultation/Testimony
US v McGrath	Southern District of Texas	Evaluation/Consultation/Testimony

US v Telles	Northern District of California	Testimony
US v Kyle Soto	District of South Dakota	Current
US v William Jon Patric Ebert	Western District of North Carolina	Blind Testimony on Grooming/Qualified Expert on Grooming and Victim Behavior
Srok v Coppola Wine Co	Santa Rosa, California	Testimony/Record Review on Behalf of Srok (Plaintiff)
State v Jerrell Bundy	New Mexico Attorney General	Testimony/Record Review
State v Morris Wright	Superior Court of California	Record Review

SCFO CIVIL CASES

Richards	Montgomery	Depo/Trial

TEXAS - SPU CASES - CIVIL

Hatcher, George	Montgomery	Depo/Trial
San Miguel, Samuel	Montgomery	Depo/Trial
Massingill, Winfred	Montgomery	Depo/Trial
Hatcher, George	Montgomery	Depo/Trial
Clemmons, Dennis	Montgomery	Depo/Trial
Black, Stephen	Guadalupe	Depo/Trial
Harris, Bobby	Harris	Depo/Trial
Sternadel, Thomas	Harris	Depo/Trial
Gray, David	Travis	Depo/Trial
Bluitt, Maurice Jr	Tarrant	Depo/Trial
Salomon, Leonel	Nueces	Depo/Trial
Williams, Jeffrey	Tarrant	Depo/Trial
Drakes, David	McLennan	Depo/Trial
Stephens, George	Orange	Depo/Trial
Hull, Donald	Jefferson	Depo/Trial
Ramshur, John	Tyler	Depo/Trial

Carden, Kenneth	Tarrant	Depo/Trial
Trevino, Richard	Webb	Depo/Trial
Falcon, Philip Jr	Newton	Depo/Trial
Rhinehart, Charles	Galveston	Depo/Trial
Cain, Leon	Tarrant	Depo/Trial
Sanchez, Justin	Tarrant	Depo/Trial
Stonecipher, Timothy	Harris	Depo/Trial
Limon, Raymond	Nueces	Depo/Trial
Vela, Juan	Nueces	Depo/Trial
Garcia, Rolando	Travis	Depo/Trial
Joiner, Gregory	Grayson	Depo/Trial
Riggs, Ronald	Gregg	Depo/Trial
Metcalf, Daniel	Bowie	Depo/Trial
Ovalle, Jose	Nueces	Depo/Trial
Shelton, Justin	Denton	Depo/Trial
Guzman, Daniel	Galveston	Depo/Trial
Throm, Robert	Jefferson	Depo/Trial
Woods, Joe	Tarrant	Depo/Trial
Barnes, Kenneth	Grayson	Depo/Trial
Farley, Gerald	Denton	Depo/Trial
Scott, David	Bell	Depo/Trial
Summers, Michael	Galveston	Depo/Trial
Wiley, Richard Sr.	Wharton	Depo/Trial
Eddings, Jeffrey	Tarrant	Depo
Pansky, Andrew	Harris	Depo/Trial
Salderna, Martin	San Patricio	Depo/Trial
Claxton, Michael	Ellis	Depo/Trial
Coles, Willie	Tarrant	Depo/Trial
West, Cedric	Dallas	Depo/Trial
Vela, Genaro	Hidalgo	Depo/Trial
Parfait, Hal Vernon	Brazos	Depo/Trial
Nolan, Gary	Bexar	Depo/Trial
Delarosa, Juan Carlos	Fayette	Depo/Trial
Mayo, Vance Allen	Ellis	Depo/Trial
Danas, March	Harris	Depo/Trial
Bohannan, Michael	Montgomery	Depo/Trial
Pena, Andrew	Hale	Depo/Trial
Brice, Gene	Dallas	Depo
Hill, William	Harris	Depo/Trial
Jackson, Derrick	Tarrant	Depo/Trial
Revels, Kendrick	Dallas	Depo/Trial

Encalade, Lonnie	Harris	Depo/Trial
Hale, Stephen	Harris	Depo/Trial
Auvil, George	Shelby	Depo/Trial
Gutierrez, Louis	Harris	Depo
Torres, Pedro	Tarrant	Depo/Trial
Nickerson, Charles	Bell	Depo
Atchison, Thomas	Harris	Depo/Trial
Encalade, Lonnie	Harris	Depo/Trial
Ybarra, Sammy	Bear	Depo/Trail
Howard, Robert	Harris	Depo/Trial

Exhibit C

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF NORTH CAROLINA
CHARLOTTE DIVISION

UNITED STATES OF AMERICA,	
vs.	DOCKET NO. 3:19-CR-244
WILLIAM JON PATRIC EBERT,	VOLUME II OF III
Defendant.	

TRANSCRIPT OF JURY TRIAL PROCEEDINGS
BEFORE THE HONORABLE FRANK D. WHITNEY,
UNITED STATES DISTRICT COURT JUDGE
THURSDAY, JULY 16, 2020 AT 8:40 A.M.

APPEARANCES:

On Behalf of the Government:

KIMLANI MURRAY FORD, ASSISTANT U.S. ATTORNEY
ERIK A. LINDAHL, ASSISTANT U.S. ATTORNEY
U.S. Attorney's Office
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Charlotte, North Carolina 28202

On Behalf of the Defendant:

JUSTIN CHRISTOPHER OLSINSKI, ESQ.
The Olsinski Law Firm, PLLC
216 N. McDowell Street, Suite 200
Charlotte, North Carolina 28204

JILLIAN M. TURNER, RMR, CRR, CRC
Official U.S. District Court Reporter
United States District Court
Charlotte, North Carolina

I N D E X

DIRECT EXAMINATION

BY MR. LINDAHL:

Q. Good afternoon. Would you please introduce yourself to our jury and spell your name for our court reporter.

A. Yes. I'm Darrel Turner. And my name is spelled D-a-r-r-e-l, Turner, T-u-r-n-e-r.

Are you the court reporter?

Q. Dr. Turner, are you working currently?

A. Yes.

Q. And where are you working?

A. Well, right now I'm working in North Carolina. I have an office in Louisiana where I'm licensed, and I have an office in Texas where I'm licensed as well. I generally travel a lot and work all across the United States.

Q. What is your position?

A. I'm a clinical psychologist, a doctor of clinical psychology, and I focus on forensic psychology.

Q. Can you tell the jurors what clinical psychology is?

A. Sure. Clinical psychology requires a doctorate or a PhD in psychology, and it is dealing with patients, testing, making diagnoses, treatment plans, generally treating patients for mental illness.

Q. You mentioned a focus in forensic psychology. Can you tell the jurors what forensic psychology is.

A. Sure. Forensic psychology is when the law and

psychology meet for whatever reason. There's certain questions that have to be answered with a knowledge of the law of a certain jurisdiction. That just means a certain place or area. And an expertise in psychology.

And so forensic psychology is when those areas combine, and my work is relevant in a courtroom setting, whether it's criminal or civil.

Q. Can you tell me how many years you have worked as a clinical psychologist with specialty in forensic psychology?

A. Sure. I was licensed in 2013, so about eight years. And then I've been doing this work under some supervision since about 2007 or 2008. So about 13 years.

Q. Dr. Turner, will you describe your educational background that led you to the career that you're in today?

A. Yes, sir. I have a bachelor's in psychology from McNeese State University in Louisiana. I have a master's degree in counseling psychology also from McNeese. And I have a PhD or a doctorate in clinical psychology from Sam Houston State University in Huntsville, Texas. I completed a predoctoral internship with the Federal Bureau of Prisons at the Federal Correctional Institution at FCI Fort Worth. And I've worked for the Federal Government as a staff psychologist and a forensic psychologist and a correctional psychologist, and I'm currently in private practice.

Q. So does that overview provide all the jobs that you've

had in psychology since you got your doctorate?
A. Yes, sir.
Q. What was your role with the Bureau of Prisons?
A. My role with the Bureau of Prisons was acting as a correctional psychologist and a forensic psychologist during my year of supervision there, which is -- I just explained what forensic psychology is. And in correctional psychology is working specifically with inmates and problems that they may have.

And then my work as a staff psychologist was at a penitentiary, which is a very high security facility, so it was responding to a lot of emergencies, sexual assaults, physical assaults, and things of that nature. So that was -- those are some of my duties with the Federal Bureau of Prisons.
Q. Thank you, Doctor.

You took us through the Government work leading up to your current role in private practice. How long have you been in private practice?
A. I've been in private practice since 2012.
Q. And you talked about being licensed in Louisiana. Is that a license in clinical psychology?
A. Yes.
Q. Do you have any certifications that you can speak to?
A. I'm certified in Louisiana on a registry to provide

treatment for sex offenders in the state of Louisiana.
Q. Dr. Turner, how much of your practice is focused now on forensic psychology?
A. I think if I had to break it down now, I'd say it's about half and half. It's about half clinical work and then half forensic work.
Q. Do you have a specialty within your forensic psychology practice?
A. Yes.
Q. And what would that be?
A. My specialty within my forensic psychology practice is in the area of sexual offending, specifically adults who sexually offend against children, how they go about doing that, how that impacts the child victims, and different aspects involved in that process.
Q. So does your specialty as you've described include a focus on a grooming practices employed by adult sex offenders who prey on minors?
A. Yes. That's a big part of what I do, yes.
Q. Would it also include minor victims and how they behave in sex abuse cases?
A. Yes, the impact of sexual abuse on minor victims, or sometimes adult victims who were offended against as minors.
Q. So in your career, have you worked with specifically sex offenders who target minor children as in met with them and

done -- and practiced with them as a patient?
A. Yes.
Q. Do you have a rough estimate as to the number of these kind of offenders that you've interviewed as part of your practice?
A. If we're just looking at interviews, so sex offenders who have sexually offended against minors that I've interviewed in one capacity or another, it's thousands.
Q. And have you also worked by interviewing childhood victims of sexual abuse?
A. Yes, either while they're still children or while -- after they've become an adult.
Q. Do you have an idea as to how many of this kind of interview you conducted in your career?
A. It would be less. It would still be a lot. I would say -- I would say it's certainly in the hundreds, but not as many as I have dealt with in the offender realm.
Q. In this specialty, specifically grooming behaviors and victim behaviors in sexual abuse cases involving minors, have you done any research?
A. Yes.
Q. Can you describe that for the jurors.
A. Sure. So I've been contacted twice by the United States Senate to participate in developing research for them in the area of adults who sexually offend against children,

profiling their personalities and some of the behaviors that we can expect to see. One of those was in about 2015, and one of those was about two months ago.

I've been contacted by the FBI, the Naval Criminal Investigative Service, Department of Homeland Security and different federal agents to consult in cases involving sexual abuse of children by adults.

I've worked with state agencies. I've worked with prosecution. I've worked with defense. I've worked directly for the courts in some cases. So lots of -- lots of different ways.

Q. So it's common for you to work on pending criminal cases involving charges related to the sexual abuse of children?

A. Yes.

Q. I believe you mentioned that for this particular purpose, you've been hired both by the prosecution and the defense?

A. Correct.

Q. Have you ever testified before as an expert witness in this area regarding adult offenders who prey on minor victims and victim behaviors?

A. Many times, yes.

Q. Would the testimony have occurred in both state and federal court?

A. Yes.

Q. How many times have you testified as an expert in adults who sexually offend against children regarding grooming practices and victim behavior?

A. I don't know. I couldn't tell you a number. You know, that's -- it's the majority of what I do.

So in most of the cases that I testify, I'm going to talk about grooming behavior. I'm going to talk about the impact of sexual abuse on a child. And that's going to be true whether I'm in court testifying or whether I'm providing training or presentation, which I've done internationally in a number of different countries.

So I can't really give you a number. It would be a lot of speculation on my part.

Q. Well, let me ask you: Have you testified in state court more than 20 times?

A. Oh, yes.

Q. More than 50 times?

A. Yes.

Q. More than 100 times?

A. Yes.

Q. And in each of those circumstances, you were accepted by the Court and allowed to give your opinion?

A. Yes.

Q. Have you testified in federal court more than 20 times?

A. Yes.

Q. More than 50 times?
A. Probably not more than 50 times in federal court, no.
Q. And in each of those circumstances, you were accepted by the Court as an expert and allowed to give your opinion?
A. Yes.
Q. And when it comes to actual in-court testimony, have you testified on behalf of both the prosecution and the defendant?
A. Yes, sir.

MR. LINDAHL: Your Honor, at this time the Government will move to tender Dr. Turner as an expert in the grooming behavior and techniques of adult offenders who sexually abuse minors and the characteristics of sexually abused children.

THE COURT: One moment. Can you repeat that?

MR. LINDAHL: Yes, Your Honor. The Government is tendering Dr. Turner as an expert in the grooming behavior --

THE COURT: Yes.

MR. LINDAHL: -- and techniques of adult offenders who sexually abuse minors and characteristics of sexually abused children.

THE COURT: All right. Would you like to voir dire the witness now or do it later in cross?

MR. OLSINSKI: Yeah, I would, Your Honor.

THE COURT: You may proceed.

Q. Dr. Turner, is there -- you testified both to grooming and the behavior of alleged victims?
A. Yes.
Q. And you've testified in both those matters 50 times, 100 times?
A. Yes.
Q. So there is -- you're telling the Court there is a set way that victims behave?
A. No. What I'm telling the Court is that there is a lot that we know about how the majority of victims behave, and there's a lot that we know about how -- the way a victim is groomed impacts the way that they behave and the way that they may or may not disclose as well as when they may or may not disclose.
Q. And when you say you know a lot, how much is a lot?
A. Enough that there are people like me that are qualified as experts to do this kind of work and testify in court on it.
Q. Well, I guess I should rephrase that question. A lot of information regarding how victims act. You know, there's no scientific conclusion on how victims act, correct?
A. Well, what we know is that there's no -- there's no corner that we can box victims into to say that a victim who is 12 years old who is sexually abused by someone with this particular relationship will behave this way. But we do know

certain things about their likelihood of, say, disclosing.
Q. Um-hum.
A. We know things about their likelihood of to whom they will disclose, how much they will disclose, based on things like whether they have a good socioeconomic background, based on whether they have a good social support group, based on -- I mean, we even know things about whether or not if they've been abused before and made an outcry before to their mother but haven't been believed by their mother, how much less likely they are to disclose if it were to happen again.

So there's a lot of information that we do know, and there's a lot of information that we can say -- that we can -- because what happens is a lot of people testify, for example, that Victim A did not do this, and this is what victims usually do. Therefore, Victim A must not really be a victim.
Q. Um-hum.
A. And that's a dangerous assumption to make. And so in the studying that we've done of victims, we're able to say, you know, that's not always the case. That's not necessarily the case. It's not fair to say that because he, you know, told two different stories across a six-month period, that he must be lying.
Q. Now, when you say you have statistics, you're talking about studies?

A. Correct.
Q. Studies you've done?
A. I've authored studies. I have one study that is published in the U.S. Bulletin. I have other studies that have been peer reviewed and presented at professional meetings or like --
Q. And those studies are on how victims react?
A. They're on how victims can react and then behavior of offenders, grooming behavior as well as victim behavior and how it is impacted by how they were groomed.

And also other information that's very important in these types of cases, such as percentages of child victims that wait at least five years before they disclose, or the percentage of child victims that wait until they're an adult to disclose, things like that that we previously thought didn't really happen.

You know, we picture kids running and finding the first adult that they can find and telling the whole story the first time. But we know from these types of studies and in talking with victims over time and publishing these studies and getting together at professional meetings and conferences and going over the data, we know a lot now that we didn't know, you know, even 10 years ago.

THE COURT: Let me cut in here.

Mr. Olsinski, are you opposing Dr. Turner as an

expert at this point?

MR. OLSINSKI: Well, I don't know that -- I haven't gotten any clarification in terms of what he testifies is nothing more than just -- you know, it may be this, it may be that. I mean, I don't know if there's -- he'd be an expert on it. It could possibly be a million other things. He hasn't given me any kind of --

THE COURT: All right. He's testified over 50 times in federal court, over one hundred times in state court.

MR. OLSINSKI: Um-hum.

THE COURT: So --

MR. OLSINSKI: Well, I mean, that may well be true. But, I mean, it doesn't add any more validity to him saying statistically, 50 percent of people disclose this way. I mean, I don't think that's --

THE COURT: Well, the Court actually has heard enough. The Court does make the determination whether an individual is qualified.

Sorry I didn't have my mic close to my mask.

So the Court at this time does believe the Government has sufficiently shown that Dr. Turner is -- has specialized knowledge and can be deemed an expert under Rule 702 of the Federal Rules of Evidence in grooming behavior and techniques of adult offenders who sexually abuse

minors and the characteristics of sexually abused children.

With that said, ladies and gentlemen, even though the Court qualifies someone or allows someone to be qualified as an expert, you still make the decisions here. And so if you want to reject the expert's testimony, you're permitted to do that. You make the determination.

But the Court has determined that the witness does qualify as an expert, as I've already claimed -- already identified the area, grooming behavior, et cetera, et cetera. But with that said, I turn it back over to the Government.

MR. LINDAHL: Thank you, Your Honor.

Q. Dr. Turner, with regard to the case on trial this week, have you reviewed any of the specific evidence in this matter?

A. No, sir.

Q. Are you familiar with any of the facts?

A. Very, very basic facts.

Q. Can you give us an idea of what you've been told before your testimony?

A. I'm aware that -- that the alleged victim has accused her biological father of sexually perpetrating against her beginning at about age 11, and that there was some delay in disclosure, and that's all I know.

Q. So with your testimony today, do you intend on offering up what's known as blind expertise?

A. Yes, sir.
Q. Can you explain what that means?
A. Yes, sir. So blind expertise is when I have not evaluated the person that's been accused of a crime. I've not read details of an alleged offense. I've not interviewed or evaluated the alleged victim of an offense.

I'm here to provide information about an area that I'm an expert in because of the work that I've done and the experience that I have in that area. And the reason for that is because there are so many common threads in these types of offenses that can be confusing to triers of fact; triers of fact being jurors or a judge.

So it's to help people that are making legal decisions understand matters where psychology and the law meet.
Q. And for your testimony today, are you being paid by the United States?
A. Yes.
Q. At what rate?
A. 250 an hour.
Q. Since entering private practice, do you charge an hourly rate in all criminal investigations or pending cases that you assist with?
A. Yes.
Q. So that would include both cases where you have been hired by the prosecution and cases where you've been hired by

a defendant?
A. Yes.
Q. I'm going to turn now to sex offenses.
With regard to sex crimes, have you found in your research a difference in matters involving adult victims with those that involve children victims?
A. Yes.
Q. Can you tell us a little about that.
A. When a child is targeted and is sexually abused, their response is going to generally be different than the response would be of an adult in a variety of ways.
Q. With that said, can you give us some unique issues that relate to child victims in these kind of cases?
A. Sure. Child victims have yet to have gained an understanding about a lot of different relationships: Sexual relationships, familial relationships, relationships with trust, romantic relationships. And so when a child is sexually abused, especially by someone that they know, it can be very confusing to that child, and it can lead to all kinds of factors that make it difficult for that child to fully disclose that they have been sexually abused by that individual.
Q. Dr. Turner, would you please define grooming behavior as it relates to sex offenses involving children?
A. Sure. So there's lots of big long definitions, but the

one that I think is most concise and that covers everything the best is grooming behavior are behaviors that are engaged in by potential child sexual predators in order to gain access to a victim, in order to increase the likelihood of that victim willingly -- and I put that in quotes because they're children, and they cannot willingly engage in sex -- but "willingly" meaning not fight back, and then prevent disclosure as best they can. In other words, prevent that child from telling anyone about the sexual abuse. And that's what grooming is, behaviors that make that likely to happen.

Q. So beyond that general definition you've provided, are there specific different types of grooming behaviors?

A. Yes.

Q. And are -- in your research and in your practice, have you found that the behaviors implemented can have a different impact when dealing with prepubescent victims when compared with adolescent victims?

A. Yes.

Q. What age range is typically associated with a prepubescent victim?

A. When we talk about prepubescent victims, we're generally talking in clinical terms of someone that's under the age of 13.

Q. And what about with regard to an adolescent victim?

A. An adolescent victim is generally referring to someone

that is older than 13 or 13 and older. And generally puberty is the mark that we're aiming for there. Someone that has either not been through puberty or someone that has been through puberty.

Q. Is there typically a difference in understanding and attitude toward sex between prepubescent children and adolescent children?

A. Yes.

Q. Can you explain that?

A. Well, quite simply, in prepubescent children, there really isn't much of an attitude towards sex. Prepubescent children don't know a whole lot about sex. They're not generally driven by sexual goals or sexual desires. They don't have sexual motives, sexual fantasies like we see in post-prepubescent children who have started to have those fantasies and started to feel sexual arousal and sexual attraction. So there's a world of difference in the two.

Q. And are there certain behaviors or patterns that occur across most cases involving an offender grooming a prepubescent child victim?

A. Can you repeat that question, please?

Q. Sure. Are there certain behaviors or patterns that occur across most cases involving an offender who is grooming a prepubescent victim?

A. Yes.

Q. Can you talk more about that?
A. Sure. One thing that we're going see in nearly every case is an effort by the offender to isolate the child victim as much as possible and as often as possible. We're also going to see a gradual, that is, an over time introduction of sex and sexual themes in an attempt to normalize sex and introduce sex to that prepubescent child.
Q. And does an isolated prepubescent victim tend to simplify an offender's ability to shape their attitude towards sex?
A. Yes.
Q. Can sexual grooming occur in family units?
A. Yes.
Q. In a parent-child relationship?
A. Yes.
Q. Are there any sexual grooming behaviors that are unique in a sex crime occurring in a parent-child relationship?
A. Well, one of the things that we see unfortunately in a situation where the sexual abuse is being perpetrated by a parent on a child, especially a biological child, is that a lot of the work involved in grooming is essentially already done for that perpetrator. They've already had access to isolation of that victim whenever they want. They can teach that victim anything they want to know about sex because they're the parent that usually teaches a child, you know,

what we hope a child is being taught about sex. So it facilitates the grooming process when the offender is a parent a great deal.

Q. What role does emotional connection have as it relates to grooming?

A. One of the things that were found in research, and in my research in particular, finding over and over is that the more people think of grooming as -- especially in younger children, fireworks, quarters, cotton candy, what we're really seeing is an effort to establish a trusting relationship.

So for younger kids, it is done a lot of times by giving gifts and things like that, but we see the gifts change when the victims get older. It might turn into alcohol or marijuana or the ability to stay out later, get away with certain things.

Q. You talked about how grooming techniques can have an impact on a child victim's willing participation in sex abuse. Can you expand upon that and describe how emotional connection might play into that?

A. Sure. So there's a study that shows that about 30 percent to 40 percent of police officers who are involved in cases where children have been sexually abused feel that the child is somehow in love with the perpetrator. A child who has been groomed, what has happened is a relationship, a

trusting emotional relationship has been formed in which that child feels a connection to the offender, which seems to go against everything that we would think.

We would think they would want nothing to do with that offender, but what we find is the offense. Very often they're very defensive of that offender. They yearn to continue to be around that offender, and they may even feel guilty or feel as though they're somewhat responsible for the abuse that took place.

Q. Dr. Turner, I want to turn you back to the family structure as it relates to these kind of crimes.

Can you tell us, what are some ways that perpetrators are able to isolate victims within a family unit?

A. Well, it's as simple as choosing which child to spend most of your time with. What we see in families where a child is being molested is that that child is very often singled out more than other children to do things with, whether it's staying up late and watch movies or go to the mall. They are very often given an ability to get away with things. They don't get in trouble for what the other children get in trouble for. Those are some of the ways that we see isolation within a family context.

Q. And how, in a family context, does minor victim's need for or effort to seek approval impact an offender's ability to groom that victim?

A. Well, if we take sex out of the picture, all of us just think for a second about how we felt about our parents when we were growing up. That's a very, very powerful relationship.

Now you imagine if that parent had inserted a sexual aspect to that relationship. It's going to be extremely confusing for that child, and it's going to give that parent a great deal of control over what that child does and does not do.

Q. Dr. Turner, can you describe the concept of normalizing as it relates to a grooming behavior in these cases?

A. Sure. We talked earlier about children who generally don't think about sex yet. They're not motivated by sex. They don't make decisions based on sex, especially if they're prepuberal.

Normalizing is when the groomer or the potential offender makes sex something that is okay to talk about, that is okay to joke about, it is okay to do. And so that's what normalizing is.

Q. Does that include conversations about masturbation?

A. Yes, it can.

Q. What about pornography? Does that play a role in some of the cases you've analyzed?

A. Absolutely, both child and adult pornography.

Q. And are there circumstances where normalizing can

include establishing a comfort level with being nude in front of the adult offender?
A. Absolutely.
Q. When we were speaking about prepubescent victims, you mentioned the origin of grooming at that point, the isolation, the beginning to expose them to sexually -- sexual topics. Do these grooming cases tend to operate in a progression where the techniques develop toward illegal sexual contact?
A. Yes, they do.
Q. Can you talk more about that?
A. Well, we don't see these cases start off with, you know, going to the movies together and then, you know, having oral sex with one another. It's a gradual thing. It's comments made about the way a child looks. You look cute in that. You look pretty today. You look pretty like your mom. It's pats on the bottom, rubbing shoulders, sexual jokes, maybe sexual pornography in the form of jokes, and then moving on to things that are and would be considered illegal. That's generally the normalizing process, and it happens over time.
Q. Dr. Turner, are there circumstances in these cases where offenders successfully normalize illegal sexual conduct in their victims?
A. Absolutely.
Q. Has -- could that include the creation of child

pornography?
A. Yes.
Q. How does that impact a minor victim's understanding of whether what they're doing is right or wrong?
A. You said the creation of child pornography?
Q. Including, yeah.
A. Well, if we're talking about creating child pornography, then we're talking about a child who is now seeing themselves naked and often engaging in sexual activities, and there's generally a threat that that is going to be shown to other people.

So as a means of normalizing sex, showing pornography is one thing. Showing child pornography to normalize sex among children in adults is another. Producing child pornography with the victim would -- would -- that's a totally different ballgame in terms of control over a victim.

Q. And a participant in that kind of contact, a victim participant, how is it the normalizing may impact their ability to know whether something like that is right or wrong if the grooming started at a prepubescent time in their life?
A. Well, because our parents are the ones that tell us what's right and what's wrong. They're the ones that tell us not to put our hand on the stove and not to cross the street without looking left and right. So if they're the ones that are also telling us that it's okay to let me take these

pictures or okay for you to take these pictures, whatever the case may be, then that's going to be looked on as the truth, especially if there has been sufficient isolation so that you don't have people in their environment telling them that it's odd, that it's wrong or that you should report that. That's the whole point of isolation as well. So I don't know if that backs over an old question.

Q. Dr. Turner, in a parent-child relationship in these cases, how does the offender use grooming to prevent the victims from reporting to other family members?

A. Well, in a lot of cases, in a majority of cases, that's done through guilt. And the guilt is often in the form of either you're just as guilty in all of this as I am; or if you tell, here are some negative things that will happen to our family as a result. I could get taken away. Your mom won't be able to support you-all, things of that nature. Those, I would say, would be the two biggest grooming factors in order to prevent disclosure in that context.

Q. Is it uncommon to see grooming occur between a parent and child in these kind of cases over a period of six years?

A. No.

Q. How does -- do these grooming techniques impact child victims as it relates to reporting after the abuse has ended?

A. Well, a lot of times when the child is considering reporting, there are two main things that they're concerned

with. One is am I going to be believed; and two is am I going to get in trouble somehow for this; with a close third being, you know, is my family going to completely implode like I've been warned they would.

And so what we see in a lot of disclosure when it does happen is it happens later. Eighty percent of the time it happens after they've reached adulthood, and we see this gradual sort of dipping their toe in the pool. So it's telling a little bit to see if they're going to be believed or if the world is going to explode; and then maybe a little while later, telling a little bit more. There's -- we tend to see a gradual progression.

But the more direct answer to your question is we're going to see a delayed disclosure process, and very oftentimes, a step-wise disclosure process.

MR. LINDAHL: No further questions, Your Honor.

THE COURT: All right. Defense witness.

MR. OLSINSKI: Thank you, Your Honor.

CROSS-EXAMINATION

BY MR. OLSINSKI:

Q. Now, you testified about the isolation phase of grooming?

A. Yes, sir.

Q. And that the person tries to keep the victim away from other people?

A. Yes, sir.
Q. Away from a reference point?
A. Right. Away from someone who will kind of undo what they've done so far in the grooming process.
Q. Okay. And that this isolation is a form of brainwashing?
A. I never used the word brainwashing.
Q. You haven't used that in previous testimony you've given?
A. I may have. I didn't use it today.
Q. Okay. So when you testified in the *United States v. David* Tellis (phonetic) on October 17th in Oakland, California, you didn't use the term brainwashing?
A. I may have. You -- you said it today, and I was just saying that I didn't say it today.
Q. Okay. But that's what you're getting at with the isolation, is to try and control the child?
A. Yes.
Q. To brainwash?
A. You could -- you could look at it like that, yes.
Q. And the whole goal of that is the further away to get from, like you said, a reference point, the easier it is to control?
A. Yes.

MR. OLSINSKI: Nothing further, Your Honor.

THE COURT: Redirect?

MR. LINDAHL: No, Your Honor.

THE COURT: All right. Can we release Dr. Turner?

MR. LINDAHL: Yes. The Government would be requesting that he be released from his subpoena.

THE COURT: Yes.

MR. LINDAHL: Yes, Your Honor.

MR. OLSINSKI: No objection.

THE COURT: No problem, right?

MR. OLSINSKI: No.

THE COURT: All right. Dr. Turner, thank you very much. You're released.

THE WITNESS: Thank you, Your Honor.

MR. LINDAHL: Your Honor, the Government is bringing in our next witness. It will be Michael Ebert. But I am requesting a sidebar before this witness testifies.

THE COURT: All right. Quick sidebar.

(At sidebar on the record:)

THE COURT: All right.

MR. LINDAHL: Thank you, Your Honor.

Your Honor, the Government is making a motion *in limine* in advance of this individual's testimony to preclude him from being able to testify about having undergone the EMDR procedure in his own therapy or any opinion evidence that may be elicited with respect to his own impact having

Exhibit D

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF PENNSYLVANIA (ALLENTOWN)

UNITED STATES OF AMERICA, Plaintiff, vs. JOHN GRAHAM DISNEY, Defendant.	) Case No: 5:12-cr-00287-JKG-1) March 5, 2013) 9:47 a.m.	FILED NOV - 5 2013

TRANSCRIPT OF JURY TRIAL
BEFORE THE HONORABLE JAMES KNOLL GARDNER
UNITED STATES DISTRICT JUDGE

ORIGINAL

APPEARANCES:

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TRANSCRIBER: JUDI Y. OLSEN, RPR

(Proceedings recorded by electronic sound recording, transcript produced by transcription service.)

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You may follow Jennifer out.

- - -

(Jury out.)

- - -

THE COURT: The jury has departed the courtroom.

You may declare a 15-minute recess.

ESR OPERATOR: Please remain seated. This court is in recess for 15 minutes.

- - -

(Whereupon, a recess was had between 3:47 p.m. and 4:16 p.m.)

- - -

(Jury in.)

- - -

THE COURT: Ladies and gentlemen, that break took a little longer than I anticipated because the attorneys and I had to discuss a few matters out of your hearing. But we have completed that now, and we'll proceed with the Government's calling its first witness.

MS. STEPHAN: Thank you, Your Honor. I call Dr. Darrel B. Turner.

THE COURT: All right.

Swear him again.

ESR OPERATOR: Please remain standing and raise your right hand.

- - -

(DARREL B. TURNER, Ph.D., SWORN.)

- - -

ESR OPERATOR: Please be seated. State and spell your name for the record.

THE WITNESS: My name is Dr. Darrel B. Turner, D-a-r-r-e-l, B., as in boy, Turner, T-u-r-n-e-r.

THE COURT: Thank you.

You may proceed.

MS. STEPHAN: Thank you, Your Honor.

- - -

DARREL B. TURNER, Ph.D.,

having been first duly sworn, was examined and testified as follows:

- - -

VOIR DIRE EXAMINATION

- - -

BY MS. STEPHAN:

Q. Good afternoon, Dr. Turner.

A. Good afternoon.

Q. Can you please tell the jurors, what is your occupation?

A. I'm a clinical psychologist. I specialize in forensic psychology and sex offending, and I'm currently in private practice in the state of Louisiana, where I'm licensed.

Q. Can you please summarize your education and experience?

A. Sure. I received a bachelor's degree in psychology from McNeese State University in Louisiana and also a master's in counseling psychology from the same school. And I received my doctorate in clinical psychology from Sam Houston State University in Huntsville, Texas.

After that, I did a year's internship at -- in the Federal Bureau of Prisons as an intern at the Federal Correctional Institute at Fort Worth, Texas, and I've since worked at the United States Penitentiary at the Federal Correctional Complex in Pollock, Louisiana.

Q. Thank you. Now, you had already testified that you have a specialty in forensic psychology and sexual offending. Can you please tell the jurors what -- what part of your background that specialty is focused on?

A. Sure. The doctoral program that I attended at Sam Houston State University has traditionally been a

forensic psychology program. While I was in school there, we were accredited as a clinical psychology program. However, most of the research tracks and courses and practicum placements dealt with things of a forensic nature.

And early on in a doctoral program, you kind of latch on to a professor and choose what kind of research you're going to do, and for me, that was violent sexual offending, risk assessment, that sort of thing. And so throughout my graduate career and since then, I've been involved in studying and publishing in that area.

Q. And have you published in that area, you said?

A. Yes, I have, several times.

Q. Numerous different articles?

A. Numerous different articles in numerous different peer-reviewed journals as well as co-authored a textbook chapter.

Q. Okay. And -- and that was on specific topics related to sexual offending?

A. Yes.

Q. And I'm sorry. You said you are licensed in Louisiana as a clinical psychologist?

A. That's correct.

Q. And you had also testified that you had worked

at the Federal Detention Center for a period of time. Can you please explain what that position entailed?

A. I worked at a United States Penitentiary after my internship. A penitentiary is just about the highest level of security that you can get, and so there's not a whole lot of therapy that goes on at that level, as you can maybe imagine. It's a lot of putting out fires, suicide risk assessments. There are numerous sexual assaults among inmates there.

And my job as a staff psychologist is -- it's kind of a fancy term for a catch-all. I get to do all the work that the fancier psychologists aren't doing.

So I do interviews with victims of the sexual assaults, assessments of this -- the offenders in those cases, confrontation avoidance, intakes, medication management, that sort of things.

Q. Okay. Can you please tell me what, if any, research you've conducted or been -- or participated in any way that pertained to sexual offending or victimization?

A. Yes. Most of the research that I've been involved with -- I would say 90 percent -- has related to sex offending. My dissertation was on the civil commitment of violent sexual offenders in

Texas, and it was the first study of its kind to poll jurors and involve them in questionnaires after the fact as to what mattered to them in their decision-making processes.

And from that study -- it was a -- kind of a large study, so we had broken it up into smaller things -- I've gotten to present to different -- at different conferences and to different organizations many times over in many different places, and it's been a good opportunity for me to -- to network and meet people.

And I'm currently conducting a study with -- with the Federal Bureau of Prisons that looks at all sex offenders -- child sex offenders in the federal system in the year 2011 that have child pornography as well as contact child sex offenses, and we're looking at things such as grooming patterns and demographics and that sort of thing. So that's -- that's a current research study that I'm involved with.

Q. Okay. And over the course of your career so far, how many sexual offenders or victims have you either counseled, treated, or evaluated?

A. It's -- it's easily hundreds. I don't know an exact number.

Q. Okay. And are you a member -- or are you -- I guess -- I guess it would be considered a member -- of the Louisiana Registry of Sex Offender Treatment Providers?

A. Yes, I am.

Q. And what is that?

A. In the state of Louisiana, you have to be a member of this registry in order to be eligible to treat sex offenders for the state of Louisiana. And the requirements are pretty rigid, and they require a -- a good amount of documentation of your hours in training and any experience that you've had in the area of treating sex offenders. And so I'm -- I'm now a member of that registry based on completion of that documentation.

Q. Okay. Based upon your specialty area -- as you said, forensic psychology with an emphasis on sexual offending -- are you familiar with the research that's been conducted and published in that specific area?

A. Yes, I am.

Q. And as part of your profession, can you tell me how research plays a role in what you do on a daily basis?

A. Certainly. It plays a huge role. It's one of

the major factors. We're ethically bound as psychologists to stay abreast of the most current research. We make very important decisions that affect people's lives, and we are expected -- it's part of our ethical code, and it's just morally right -- to know what the most current treatments are, what the facts state, what the numbers are looking like, how things are changing in the population with, for example, the advent of the Internet, things like that.

So just as a medical doctor has to stay abreast of -- of new medications and things that work -- so that they don't maybe have to amputate your leg; they can give you a pill for it -- we have to stay abreast of -- of what's new and -- and what's current in our field as well.

Q. And have you done that specifically in the area of sexual offending?

A. Yes, I have. Especially because I work in that area and publish in that area, I have to stay abreast of -- of the most recent and important articles, yes.

Q. Okay.

MS. STEPHAN: May I approach the witness, Your Honor?

THE COURT: You may.

BY MS. STEPHAN:

Q. Dr. Turner, I just handed you what's been premarked as Government's Exhibit Number 1. Do you recognize this document?

A. Yes, I do.

Q. And what is it?

A. This is a copy of my CV, or my curriculum vitae.

Q. Does it accurately -- does it accurately reflect your education, background, including, basically, your jobs, any kind of publications, or teaching assignments that you've had?

A. It does, yes.

Q. Thank you.

MS. STEPHAN: Your Honor, I move for the admission of Government's Exhibit Number 1.

THE COURT: Any objection?

MR. COOPER: No, Your Honor.

THE COURT: In the absence of objection, Government's Exhibit Number 1 is received into evidence.

- - -

(Whereupon, Exhibit Government's-1 was admitted into evidence.)

- - -

BY MS. STEPHAN:

Q. Dr. Turner, through your contact with sexual offenders, do you gain insight and understanding into the ways sexual offenders succeed in committing their crimes, including such things as grooming behaviors?

A. Yes, I do.

Q. And I think you may have already testified, but has that been a focus of your -- your own professional goals?

A. It has. It's been a focus of treatment. It's been a focus of interest in risk assessment and certainly in research that I have conducted and am conducting and plan to publish.

MS. STEPHAN: Your Honor, at this time, I'd like to move this expert in as an expert in clinical psychology with an emphasis in forensic psychology and sex offending.

THE COURT: Do you care to cross-examine on qualifications, Mr. Cooper?

MR. COOPER: Briefly, Your Honor.

THE COURT: You may do so.

- - -

VOIR DIRE EXAMINATION

- - -

BY MR. COOPER:

Q. Good afternoon, sir.
A. Good afternoon.
Q. Have you ever been qualified before as an expert in the field of clinical psychology with the emphasis on sex offender treatment?
A. No, I have not.
Q. And how long have you been a clinical psychologist with this area of specialty?
A. I received my Ph.D. in 2011, and I've worked before and since that time in -- in this field.
Q. Okay. And when you've worked before and since that time in this field, your work before, as you testified before, was with your internship and working in the federal penitentiary; is that correct?
A. No, sir. I've worked in the federal penitentiary since I've -- since I've graduated --
Q. Okay.
A. -- as a staff psychologist.
Q. All right. And in your testimony, have you ever been asked before today to be an expert, to be qualified as an expert?
A. No, I have not.
MR. COOPER: Thank you very much.
THE COURT: All right. Any redirect on qualifications?

MS. STEPHAN: No, Your Honor.

THE COURT: Mr. Cooper, any objection to the qualifications of this witness to render expert opinions in the field of clinical psychology with an emphasis on forensic psychology and sex offending?

MR. COOPER: No, Your Honor.

THE COURT: In the absence of objection, I find Dr. Turner qualified to render expert opinions in that field and in those fields.

What weight, if any, will be given to the opinions of the expert will be determined by you, the jury.

You may examine him on the merits.

MS. STEPHAN: Thank you, Your Honor.

- - -

DIRECT EXAMINATION

- - -

BY MS. STEPHAN:

Q. Dr. Turner, can you please tell me what is meant by grooming?

A. Grooming is a term used to describe behaviors that a sex offender engages in primarily to get victims, to keep victims, and to get victims to not tell. That's sort of a -- a nutshell definition of what grooming is. It's -- of course, it's much more

complicated than that, but --

Q. Can you give some examples of types of grooming behaviors that you're familiar with or that you see frequently based upon your education and research?

A. Certainly. Some of the more common types of grooming behaviors involve overexposure of the intended victim to sexuality, whether it's exposing the victim to other images -- and I'm speaking of a child victim -- whether it's exposing that victim to other images of child pornography, whether it's exposing that victim to other images of pornography in general, adult pornography, whether it's talking about porn -- pornography, talking about sex. Anything that can normalize sex, that's a common technique that's used.

The use of alcohol is -- is -- is a very -- one of the more common grooming techniques as well.

Threats, sometimes direct physical threats, sometimes more indirect covert threats that play on guilt and fear.

Q. Do grooming behaviors have any impact on victim resistance?

A. Yes, they do.

Q. And can you please tell me in what ways you see that?

A. One of the -- one of the primary functions -- functional behaviors in grooming is going to be isolation. Isolation is one of the most, if not the most, important factor in grooming.

The reason for that is, a child having sexual contact with an adult is against the law, and -- and it's bad, and it doesn't happen all the time. And we, as a society, do a good job or -- or do our best to make sure that that doesn't happen. We warn our children. We talk to our children. We have commercials and things like that, teachers, educators.

And during the grooming process, an offender wants to get their intended victim as far away from those warnings as possible. They want to isolate that victim. They want to basically destroy that victim's frame of reference.

And when I say "frame of reference," I mean anyone or anything that could remind that child that, hey, this isn't normal; this isn't good; this isn't supposed to happen.

So if -- if a child is successfully isolated, successfully according to the offender, then that child's sense of what's happening and -- and the rightness of it and the goodness of it, and, in some

cases, the -- the fun of it, depending on -- on what nature the grooming takes, becomes very warped.

The child is removed from their social support system, from the people that would normally act as their frame of reference and as their protectors, so much so that the offender oftentimes becomes the only social support system that remains for the victim.

And -- and when that occurs, you can imagine that -- that there's little chance for that victim to have a normal response to the abuse.

Q. Can you tell me how alcohol fits into what it is that you just talked about?

A. Certainly. Alcohol is, from an offender's point of view, from a groomer's point of view, an extremely effective tool. I think we're all aware that alcohol acts as an inhibition-lowerer. When human beings consume alcohol, the larger amount of alcohol you consume, the more willing you are to do things that you wouldn't normally do.

In the area of child sex offending, it -- it does more than that. Because you're -- because you're dealing with children -- so not only are you lowering inhibitions, but you're establishing a sense of -- I don't know if trust is the right word, but you're establishing a sort of special relationship,

in that, this is our secret; no one knows about it; I'm giving you alcohol; you're drinking alcohol; you're having a good time drinking the alcohol; maybe your friends are involved; maybe they're not.

And that causes the victim to question their own sense of responsibility in the abuse. You know, I -- I -- I did have fun; my friends were there; does that mean that I -- does that mean that I enjoyed this as well; I've been being told that this is normal; I've been being shown these images.

It becomes very, very, very, very confusing; and it makes it less likely that the victim will come forward or will ever seek help.

Q. Can you please further elaborate on that point? Based upon your education and your research and your clinical experience, when alcohol is provided by a sex offender to an adolescent or a teenager and the teenager or adolescent accepts it and drinks it -- and you -- you -- you just talked about this -- this secret sort of relationship exists -- how does that impact, if in any way, reporting, disclosing, telling anybody about what's going on?

A. One way that it does that is that children feel bad -- and if they don't, they're most certainly told by the offender that they should feel bad for

consuming alcohol or that it's wrong.

And so you get the sense that even if I do come forward, I've done enough -- I've done enough bad things that I'm not going to be believed; my -- my credibility is shot. So here I am now, this troubled child that drinks and shouldn't drink and is doing all these things and looking at all these pictures, who's -- who's going to believe me?

So that's probably the -- the most -- one -- one of the more negative ways or powerful ways that alcohol can impact coming forward.

Q. And have you seen this in -- in your background and research?

A. Absolutely, yes.

Q. Now, you touched upon two -- showing of pornography, showing adult pornography. I think you testified about reducing inhibitions. Can you -- can you talk a little bit further about how that impacts a victim and allows for victimization?

A. Certainly. We -- we talk about normalizing sexuality in children as part of the grooming process. As I said earlier, a child having sex with an adult is not normal in our society, so the offender wants to make it appear normal. They want to almost -- you can think of it as re-parenting, if

you would. So you're re-teaching.

During your opening statements, you mentioned, you know, I'll show you, or let me show you, as you talked about the videos and things like that. Constantly talking about sex, constantly seeing these images, coupled with isolation, coupled with alcohol, coupled with a poor, perhaps, social support structure to begin with, and the -- the thought that sex is bad or that sex as a child with an adult is bad, it becomes a -- it becomes a hazy ground. It's not as clear as it once was, especially as day after day after day after day, they're being reinforced.

And sometimes it's -- sometimes it's not as much of a threat as it is just a simple -- the simple fact that the child is getting attention from someone.

A lot of these children that are victims come from -- from homes where their social support system is nonexistent. And so simply getting attention from an adult, even if it's -- even if it's strange or bad attention, can be very rewarding for these victims.

Q. Okay. I believe that you've probably touched on this already, but can you tell me, what are counterintuitive behaviors of sexual assault victims?

What does that mean?

A. We tend to think as a society that when a child is victimized, he or she runs screaming to the first house that they can find and bangs on the door and tells someone and the police are called and everything is taken care of.

Research shows that this is not the case at all. 60 to 80 percent -- we -- we understand now, through multiple research studies, that 60 to 80 percent of victims of child sexual abuse don't disclose their abuse until they become an adult.

There's a lot more statistics. I don't know how many of them you want me to get into.

Q. Well, let me -- let me just start with this. When you refer to a child --

A. Um-hmm.

Q. -- are we referring to basically anybody under the age of 18?

A. Correct.

Q. Okay. So research that you're talking about talks about all different age ranges?

A. Is generalized to anyone under that age, yes.

Q. Under 18, okay.

So can you tell me, when -- when you're talking about counterintuitive, you're saying that -- that

some people may think that most victims cry out and report immediately, maybe tell a parent immediately, fight back physically. You're saying that in your research and experience that that is actually not the norm, not what is seen most times?

A. That's right. That's more the exception than the norm. Most of the time, there's going to be at least a delay. In 58 percent of the cases, it's at least a five-year delay in reporting anything at all, and usually that's just from the onset of the victimization.

Q. Is there such a concept as family grooming?

A. There is, yes, or environment grooming. And that is when you -- as an offender, there's not only grooming of the victim, of the specific child, but there's grooming of the environment as well. There's establishing a trust -- a trusting relationship with parents. There's, you know, I'm isolating this child, and I'm spending a lot of time with this child because I want to help this child, or because I want to provide this child with the -- you know, whatever parental support they never got.

I mean, it varies from case to case, but there is. And sometimes that involves taking a position in -- in society that -- that simply allows access to

children, frequent access to children.

So environmental or family grooming can mean -- means both. It means establishing the trust of the caregiver so that they're likely to allow you access to their child or the victim, and it also means putting yourself in a position where it would make sense, because of the job you have, that you would have that access; you're a daycare worker, whatever the case may be.

Q. Would an example of that include a situation in which a perpetrator would say to a parent -- a mother, a father, or a parent -- that they were helping the victim, for instance, with an alcohol problem?

A. Certainly, yes.

Q. And if I understand you correctly, it -- it's a manner in which to convince the parent or guardian that your intentions are good and not bad?

A. Right, that your intentions are to help the child, that you -- whatever the case may be. A good -- someone that's good at grooming is going to be able to touch whatever buttons they need to touch in the parents to get frequent -- what's the word -- unsupervised access to the children.

And then, also, that becomes -- that feeds on

itself in terms of family grooming because, in a sense, what they're doing also by establishing that trust is if -- if the child ever does disclose, then they have this sort of ground work that they've laid as to, hey, I was -- we all knew what a troubled child this was; I was helping; you know, what -- can you believe this; this is what I get for trying to help and be a good person, that sort of thing.

Q. Okay. Do you see fitting into that any attempts by a perpetrator/offender to try to alienate the child from its caregiver or parent or try to create any kind of, like, rifts between a child and a parent?

A. That's extremely common, and -- and it's -- it's seen with great frequency, along with the use of alcohol and discussion and showing of pornography to a -- to an intended victim as being one of the -- the main or preferred types of grooming, yes.

Q. Okay. And what can you tell me about a victim's either lack of support structures or, you know, how that compares to victims who have good support structures? Is -- is -- do you see any kind of correlation between counterintuitive behaviors and -- and disclosures with victims who have no support compared to those who do?

A. Yes.
Q. If you understand that question.
A. I do.
Q. Okay.
A. I do. When you say "counterintuitive behaviors," you refer to what we were talking about earlier in terms of maybe not disclosing right away --
Q. Right.
A. -- or maybe not even necessarily trying to distance themselves from the offender, and -- and that happens all the time. And a big push in research is to kind of get that to be not considered a counterintuitive behavior anymore, because it's actually not; it's more -- it's more normal.

So -- and research does show a strong relationship between a troubled home life or lack of good, solid, consistent support system to a likelihood of not disclosing or disclosing at a much later date or even disclosing to maybe -- maybe friends or anyone other than parents, police, authority.

They're afraid that they're not going to be trusted. They're afraid that they're going to be blamed for not stopping it themselves. And this

is -- and this is what's kind of counted on by the offenders, unfortunately.

Q. Can you tell me, following up on that, whether or not self-esteem issues or lack of self confidence plays any role in victimization?

A. It can, especially if the offender can pick up on that and can use that as part of the grooming process. So not only -- it kind of goes with what we were talking about earlier about any attention. So -- so even negative attention -- but it doesn't have to be negative attention. It can be, this is the person -- this is the only person in their life telling them that they're attractive or that they're smart or that they're fun to be around or that they're photogenic, whatever the case may be.

Q. Okay. And what about a victim feeling shame? How does that impact their behaviors?

A. It -- it goes hand in hand with abuse. It certainly goes hand in hand with abuse that involves the use of alcohol, because alcohol does lower inhibitions and -- and alcohol does affect -- I mean, everything. It affects everything. And it -- it is --

Shame and fear are -- are probably the two -- the two biggest emotions that are shown in the

literature and that I've seen in my experience that are experienced by victims. They are -- they are afraid of what may occur, sometimes physically, but they're also -- they're also quite ashamed.

And it's not necessarily a fear of what may happen to them, but sometimes the offenders tell them, you know, I'll -- sometimes it can be as blatant as, if you tell anyone, I'll kill your mother, or I'll kill your father, and sometimes it can be as passive as, well, you know your father would kill me if he ever found out, and you know what would happen to your family if that -- if that were to happen; he'd go to jail, and they'd all end up, you know, blah, blah, blah.

So there's this -- there's the sense of fear, and then there's also the sense of shame, recognizing -- disclosing that you've been abused means recognizing and admitting that you've been abused, and -- and that's an extremely shameful and horrible thing to have to admit to yourself and to everyone in your world, especially as a child.

Q. Thank you.

Based upon your research and experience, have you seen any situations where the victim fails to report or disclose because they want to protect a

loved one in some way or -- some way?

A. Certainly. That's very common. There's a lot of pressure that victims often feel to hold the family together. In some cases, it's, I don't want to be a cause for my parents splitting. Or in some cases I've seen it's, I don't -- if I don't take this abuse, then it will -- it's going to be one of my siblings.

So it's a lot of -- it's a lot of pressure that's felt by the victim -- by the child victim to -- to hold -- hold the family together, and -- and the only way to do that is to -- to not say anything, because saying something would be so explosive that -- that the family would then have all these huge problems which are, of course, their fault, or that's how they would feel.

Q. Would it follow from that that if a victim didn't want to disclose because -- felt like a parent would be harmed or put in a worse situation because of a disclosure, that they decide to wait and not say anything?

A. Certainly. That's a -- that's a very big factor in waiting to disclose.

There's also a direct relationship between female victims that have sort of a troubled

relationship with their mothers and hesitancy in disclosing or not disclosing at all. That's a very strong relationship that the research has showed.

Q. Okay. And what about fighting back? Is it normal for a victim to fight back, or is it not normal, based upon your education and research?

A. I would say it's -- it's more -- it happens more often that a victim doesn't fight back, and if they do, it's not -- it's not for very long. Again, these are children, and for all -- all of the same reasons that they're scared to disclose, they're -- they're scared to fight back.

Usually -- usually fighting back occurs, if it -- if it is going to occur, it occurs early on and -- and not for long.

Q. Okay. And how does grooming behaviors like the giving of alcohol or exposure to adult pornography affect a -- a child deciding to fight back or not?

A. Well, that -- I mean, that -- that's the kicker. If the grooming is done to a certain degree or if the -- if the grooming punches all the right buttons and uses all of the right tools and techniques, then the likelihood that the child is going to fight back becomes less and less.

You can almost think of it as -- in terms of

if -- if someone were to try to sexually assault a child the first time they met them, there's a pretty greater chance that the child is going to run away or tell someone. But what research shows us is that eight out of ten child sexual assault victims know their offender.

And so there is this process. There is this sort of foot-in-the-door technique of kind of they're okay with this, then they're okay with this, and this makes them feel weird. But then it becomes more and more of a car salesman giving you more and more and more, and you need that TrueCoat, and so on and so forth until -- and that's kind of the process that's used.

Q. Okay. Thank you.

MS. STEPHAN: I have no further questions at this time, Your Honor.

THE COURT: All right. You may cross-examine.

MR. COOPER: Thank you, Your Honor.

- - -

CROSS-EXAMINATION

- - -

BY MR. COOPER:

Q. Good afternoon, sir.

A. Good afternoon.
Q. I want to go over some of the particulars of the testimony that you just gave.
First of all, when you are doing your work in clinical assessment, you are talking with people, and you're looking at documentation to either confirm or deny what's being reported; is that correct?
A. That's correct some of the time, yes.
Q. Some of the time, that wouldn't be correct. Some of that time, there would be simply the reporting by the alleged victim?
A. That's correct.
Q. And the determination is being made based on what that particular person tells you, as far as your -- your knowledge of the field is concerned; is that correct?
A. Yes. If I understand the question, that's correct.
Q. And that's for purposes of treating that victim; is that correct?
A. Correct.
Q. For what they claim to have happened to them; is that correct?
A. That's correct.
Q. And this is not done for assessment to say --

to go into court and to testify as to the credibility of this particular person; is that correct? You don't do that?

A. No, I don't do that. I've also never testified in that capacity.

Q. Okay. And as far as the -- the -- the information that is being given to you, it's being given to you pretty much in terms of a therapeutic or clinical environment, is that correct?

A. That's correct.

Q. And that would not be what would be called a forensic environment? And what I mean by "forensic," I mean like a courtroom, where there would be direct examination, cross-examination, questions about bias, questions about motive, any of those things. Is that correct?

A. I have conducted a risk assessment before, and I did use collateral information and so on and so forth. But if you're talking about terms of treatment, then -- then yes. And if -- if it's not a court-related issue, then you're right; it's generally what's reported to me.

Q. Now, you've also examined sex offenders; is that correct?

A. Yes.

Q. Or you're treating sex offenders or assessed sex offenders; is that correct?
A. Yes.
Q. And you assess them for purposes of what the problem might be and future risk and treatment needs and things of that nature, is that correct?
A. Correct.
Q. And that would be offenders that would be adults mainly?
A. Yes. I've also worked with juveniles before, but primarily adults.
Q. Primarily adults?
A. Yes.
Q. And when I say "adult," this would be anybody over the age of 18?
A. Yes.
Q. And up to whatever?
A. Correct.
Q. Okay. And as far as when you talked to those sex offenders and the age ranges, if you talked to -- have you talked to sex offenders that are in the age range of 50 and above?
A. Yes.
Q. How many times?
A. I -- I -- I don't remember.

Q. Okay. Well, you've done -- you said you've talked to hundreds?
A. Yes.
Q. But you don't know how many as far as that age group is concerned; am I understanding you right?
A. That's correct.
Q. Okay. And you do remember talking to some in that age group; is that correct?
A. Yes.
Q. And when you've talked to some in that age group and they give you their history of what they did in terms of the abuse or their patterns, okay, they had -- if they were 50 and above, they had a long history of doing this; is that correct?
A. Not necessarily, no.
Q. In some cases, yes, and in some cases, no?
A. Correct.
Q. It would just depend on who said what; is that correct?
A. Yes.
Q. Okay. You also said that -- and I want to be sure I'm accurate when you -- you say that -- you said that the studies are that eight out of ten of the victims of sexual abuse know who the perpetrator is, know them before that; in other words, know who

they were --
A. Yes.
Q. -- is that correct?
A. Yes.
Q. And that is based on the research studies; is that right?
A. Yes.
Q. And the research studies are based on the same type of information that you're getting, which is the clinical evaluation; is that correct?
A. Research studies can be based on a -- on a variety of information.
Q. Okay. It could be information just like you talked about doing or other types of information; is that correct?
A. Correct.
Q. The general knowledge is that eight out of ten know who the perpetrator of the assault is; is that correct?
A. Correct.
Q. And then you also said that, if I'm -- if I'm correct -- I want to do some numbers just to make sure that I'm accurate on the numbers.
Did I hear you say 60 to 80 percent of the victims don't disclose until they reach adult age?

A. 60 to 80 percent of victims who do disclose do not do so until they've reached adult age.
Q. Okay. 60 to 80 percent of those disclose [sic] until they reach adult age. So that means -- does that mean that 20 to 40 percent will disclose it immediately, even if they're under 18? Is that what that means?
A. No, sir.
Q. Okay. Does it mean that in the cases that you've -- that you've studied, the cases vary, meaning that sometimes -- sometimes a victim will disclose it immediately? Is that correct?
A. Certainly.
Q. That does happen?
A. Yes, sir, absolutely.
Q. And it happens when -- let's say they're under the age of 18, between the ages of 14 and 18. Let's -- let's deal with that age range. Okay? In the age range of 14 to 18, what is your research information, if you have it, of those that do disclose it immediately?
A. What is my research information in terms of what percent disclose immediately?
Q. If you have it.
A. In that age range, I don't have that. I do

have a study that looks at children in general and -- and those that disclose immediately. I could look at that if you like, but it's not -- it's not specific to 14 to 17 year olds.

Q. Okay. Would that be specific to children under the age of 18?

A. Yes, sir.

Q. And that would be ages lower than 14?

A. It would include ages lower than 14, yes, sir.

Q. And it doesn't break it down by age in terms of which percentage in what age group? It doesn't -- the study doesn't do that?

A. No, sir.

Q. Now, you also said that -- if I understand you correctly, that in the delay -- when you said -- you talked about a five-year delay sometimes that happens. I want to make sure I heard you right. Did you say 50 percent involve a five-year delay? Am I stating that accurately?

A. 50 per -- I'm sorry. 56 percent --

Q. 56?

A. -- of those who disclose have at least a five-year delay between the onset of victimization and their disclosure.

Q. Okay. 50 percent of those -- 56 percent of

those who disclose, there's a time gap of event versus disclosure of five years?

A. Of at least five years, yes.

Q. Now, you said before, when I asked you earlier, this is the first time you've ever testified as an expert in this field?

A. Yes.

Q. And you are -- in your work that you've done and the studies that you've done and the -- and the research that you've done -- are you in private clinical practice now?

A. Yes, I am.

Q. And for how long have you been in private clinical practice?

A. I've been in private clinical practice for about two weeks.

Q. And before that, if you were not in private clinical practice, you were working as a staff psychologist, for example?

A. Yes.

Q. And that would have been at the federal penitentiary?

A. Yes.

Q. And before you worked at the federal penitentiary and being a staff psychologist, you

worked as an intern in the Federal Bureau of Prisons.
A. Yes.
Q. And you also did some internships.
In your work right now -- in your clinical work right now, how much are you being paid to testify today, if anything?
A. 250 an hour.
Q. $250 per hour?
A. Yes.
Q. Okay. And you come from Louisiana; is that correct?
A. Yes.
Q. You traveled from Louisiana?
A. Yes, I did.
Q. Okay. And that's being taken care of as well?
A. Yes.
MR. COOPER: May I have a moment, Your Honor?
THE COURT: You may.
THE WITNESS: I'm not reimbursed --
I'm sorry. May I say --
THE COURT: Yeah, you may complete your answer.
THE WITNESS: Clarify. I'm reimbursed for travel at a lesser rate than 250 an hour.

MR. COOPER: Understood.

THE WITNESS: Okay.

- - -

(Pause)

- - -

BY MR. COOPER:

Q. The last question is, with this particular matter that's in court, the United States versus Disney, you have not interviewed anyone with respect to that; is that correct?

A. That's correct.

Q. Okay.

MR. COOPER: That's all I have, Your Honor. Thank you.

THE COURT: All right. Any redirect?

MS. STEPHAN: Very brief, Your Honor.

THE COURT: Go ahead.

- - -

REDIRECT EXAMINATION

- - -

BY MS. STEPHAN:

Q. Dr. Turner, can you tell me what psychologists in your profession can learn through interviews or treatment of sex offenders?

A. We can learn a great deal. Interviews and

treatment -- if -- if a -- if a sex offender is -- is engaged in treatment, we can oftentimes learn things about their grooming behaviors, things about their past, things about their -- their thinking, their planning, their degree of empathy, their sex -- degree of sexual deviance. We -- we learn things about their history, their criminal history, everything that we can.

Q. Okay. And would you say a fair number of research is focused on learning things through the sexual offender rather than the victim?

A. Yes.

Q. And during your time working for the -- a Federal Detention Center -- I forget. What -- what was -- what is the name of the place you worked?

A. United States Penitentiary.

Q. United States Penitentiary?

A. Um-hmm.

Q. Were you permitted to engage in something of this nature, being called as an expert in a case like this?

A. No, I was not.

Q. Can you just explain?

A. There's a conflict of interest in working as a staff psychologist conducting therapy with inmates

and testifying in federal court in this nature. So I was not allowed to do that --

Q. Okay.

A. -- as an employee of the Bureau of Prisons.

Q. And you worked there for the past two and a half years; is that accurate?

A. Yes.

Q. And during your time at the federal penitentiary, did you have occasion to have contact and counsel sex offenders?

A. Yes, I did.

Q. Thank you.

MS. STEPHAN: I have nothing further, Your Honor.

MR. COOPER: No recross, Your Honor.

THE COURT: All right. Attorney Stephan, is this witness excused from further participation in the trial?

MS. STEPHAN: Yes, please.

THE COURT: Any objection from the defense?

MR. COOPER: No, sir.

THE COURT: All right. Dr. Turner, you are excused. Thank you for your testimony. And you may step down, and you may leave if you wish.

THE WITNESS: Thank you.

THE COURT: You may stay, if you wish. It's a public trial.

THE WITNESS: Thank you, Your Honor.

- - -

(Witness excused.)

- - -

THE COURT: May I see counsel briefly at the bench, not for the record.

- - -

(Whereupon, there was a brief sidebar conference held off the record.)

- - -

THE COURT: The attorneys and I are going to have to be in court another 45 minutes or so on things we need to discuss and decide out of your hearing to make it run more smoothly for you when you're in the courtroom, and so we're going to excuse you for the evening in a moment, but not them.

And we'll ask you to return tomorrow morning a few minutes before 9:30, and we will attempt to resume the trial at that time with the next witness.

Leave your notes on your chairs. My staff will lock them up.

Exhibit E

UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF FLORIDA
ORLANDO DIVISION

UNITED STATES OF AMERICA,	)	
	)	
Plaintiff,	)	Case Number
	)	
v.	)	6:15-cr-226-Orl-41GJK
	)	
DANE GILLIS,	)	
	)	
Defendant.	)	
	)	

Transcript of the sentencing

before the Honorable Carlos E. Mendoza

September 21, 2016; 9:04 a.m.

Orlando, Florida

Appearances:

Counsel for Plaintiff: Karen L. Gable
Emily C.L. Chang

Counsel for Defendant: Karla M. Reyes
James T. Skuthan

Proceedings recorded by mechanical stenography, transcript produced by computer.

Diane Peede, RMR, CRR
Federal Official Court Reporter
401 West Central Boulevard, Suite 4600
Orlando, Florida 32801

Index of transcript

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that's not yours and I'll have them clean up after you.

Ms. Reyes, do you have any further witnesses to call at this time?

MS. REYES: No, Your Honor.

THE COURT: Will your client be making a statement to the Court before we move on to the government's case?

MS. REYES: Can he be the last one to speak, Your Honor?

THE COURT: He can be the last one.

MS. REYES: Thank you.

THE COURT: Ms. Gable, do you have any witnesses you'd like to call at this time?

MS. GABLE: We do, Your Honor. We call Dr. Darrel Turner.

THE COURTROOM DEPUTY: Please come forward and be sworn. Raise your right hand.

Do you solemnly swear or affirm under the penalty of perjury that the testimony you give will be the truth, the whole truth and nothing but the truth?

DR. DARREL TURNER: Yes, ma'am.

DARREL TURNER, PLAINTIFF'S WITNESS, SWORN

THE COURTROOM DEPUTY: Have a seat there, please.

THE COURT: All right. And once seated, please make yourself comfortable with the chair's proximity to the microphone, state your full name into that microphone,

spelling your last name.

THE WITNESS: Yes, Your Honor. My name is Dr. Darrel Turner, last name T-u-r-n-e-r.

THE COURT: Ms. Gable, your witness.

MS. GABLE: Thank you.

DIRECT EXAMINATION

BY MS. GABLE:

Q Good morning, Dr. Turner. What do you do for a living?

A I'm a clinical and forensic psychologist.

Q Where do you practice?

A I'm sorry. I'm licensed in the states of Louisiana and in Texas.

Q Did you go to school?

A I did, yes.

Q Where did you go to school and what degrees did you receive?

A I have a bachelor's degree in psychology from McNeese State University in Louisiana, a master's degree in counseling psychology from the same institution, and a Ph.D. in clinical psychology from Sam Houston State University in Huntsville, Texas.

Q Do you conduct psychosexual risk assessments?

A I do, yes.

Q What are those?

A It's the use of factors that are supported in research

to be either risk factors or protective factors. It's looking at all of them in totality, and it is determining, based on those research-supported factors, to what degree a person represents risk to re-offend.

Q How many risk assessments have you conducted?

A I don't know an exact number. It's hundreds. It's -- I would say it's the majority of my forensic practice.

Q And in what capacity or for what agencies have you conducted risk assessments?

A I work with the State of Texas. There's a Civil Commitment Program there for sexually violent predators, and I've worked with the defense as well as prosecution in that context. I've worked with federal defense attorneys, federal prosecutors, local, state defense and prosecutors, sometimes court-appointed as well.

Q Have you conducted any research or done any research in the area of psychosexual risk assessment?

A I have, yes.

Q What kind of research have you done?

MS. REYES: Your Honor, pardon the interruption. As stated earlier, we are willing to stipulate to Dr. Turner's expertise.

THE COURT: And I appreciate the collegiality there. I will tell you that your expert that just testified, I was able to consider her entire curriculum vitae when she

testified at the motion in limine. While that's a very generous offer to the government, I'm going to leave it to them as to whether or not they want to lay it out.

I don't have a C.V. on this witness that I have on yours. I don't know anything about this witness. So, Ms. Gable, the ball is in your court on this one.

MS. GABLE: Thank you.

BY MS. GABLE:

Q Are have you conducted research in the area of psychosexual risk assessment?

A Yes, I have.

Q And what research have you conducted?

A I've published numerous studies in the area of -- well, the broad area of risk assessment of sex offenders, risk assessment of adults who sexually offend against children, ethical considerations in sex offender risk assessments. That was a textbook chapter that I co-authored.

I was contacted recently by the F.B.I.'s behavior analysis unit to participate or collaborate in a study on risk factors among contact child molesters as well as non-contact child pornography offenders.

I've done research on grooming. A large part of my practice is research. I'm a bit of a nerd in that way.

Q Have you received any training in the area of psychosexual risk assessment?

A **Yes, I have.**

Q **What kind of training have you received?**

A **The program that I attended at Sam Houston State University, it was a clinical program, but the majority of the practicum placements and a lot of the specialized classes that you could take were in the field of mental health and law, forensic psychology.**

I've worked at numerous correctional facilities, juvenile and adult. My predoctoral internship was with the Federal Bureau of Prisons, and my first job was with the Federal Bureau of Prisons.

Q **Dr. Turner, at the request of the United States have you conducted a psychosexual risk assessment of the defendant, Mr. Gillis?**

A **Yes, I have.**

Q **And in preparing for your assessment, did you review documents in this case?**

A **I did, yes.**

Q **What did you review?**

A **I reviewed the -- quite a bit, actually. The Superseding Indictment. I reviewed the computer evidence; the adult B.D.S.M., which is bondage sadomasochistic pornography, as well as child erotica that was seized from his computer; various photographs of the victim, Michelle; trial Exhibit 17 -- well 12 through 17, which were various**

pictures and photographs; transcripts of his e-mail correspondence with other Craigslist users; a summary of his e-mail correspondence with the undercover agent; the thank you note to Mr. Gillis from the victim, Michelle; transcripts of e-mails between the defendant and various other parties related to kidnapping and rape of the adult victim; his Internet search history and his Internet -- so his search-specific titles that he used to search as well as his Internet history that was obtained during the forensic examination by the government; his Samsung Galaxy extraction report; the Bing toolbar search terms obtained during the forensic examination; a summary of his interview with the F.B.I. subsequent to his arrest; a copy of the polygraph examination; a CV of Dr. Sullivan; Dr. Sullivan's report; Dr. Sullivan's handwritten notes; a partial trial transcript of U.S. versus Dane Gillis; and then the testing results for the in M.M.P.I., the Abel, the P.C.L.R. as submitted by Dr. Sullivan; the United States Attorney's Sentencing Memorandum. That's just about it.
Q After reviewing all of that material, have you formed an opinion regarding the defendant's risk to re-offend sexually?
A Yes, I have.
Q What is your opinion?
A My opinion is that he represents a high risk to re-offend sexually.

Q **What is the basis of your opinion?**

A **The basis of the opinion uses empirically supported risk factors. It's factors that are shown across research studies to increase or lower a person's degree of risk of re-offending sexually.**

Q **In the field of risk assessment, are there predictors of sexual recidivism?**

A **Yes.**

Q **What are those predictors?**

A **Well, the two largest predictors of sexual re-offending are the presence of antisociality, which is antisocial beliefs, personality, usually indicated by behaviors as well. So because they have these personality characteristics, they tend to act a certain way. And that's one of the biggest risk factors.**

The second most powerful predictive risk factor is degree of sexual deviance.

Q **What is "sexual deviance"?**

A **"Sexual deviance" can be sort of defined differently by different people, but essentially it's just a sexual attraction to something, in this case something that would require victimization. It can be indicated by a fetish, sexual attraction to an inanimate object, children, sadism. All those are considered sexual deviancy.**

Q **Is there an authoritative manual in the practice or**

field of psychology that psychologists use to diagnose sexual deviancy?

A Yes.

Q What is that?

A Well, used to diagnose paraphilias, yes, and that's the Diagnostic and Statistical Manual-5, the D.S.M.-5.

Q Do you have an opinion as to whether or not the defendant meets the criteria, the diagnostic criteria for any sexual deviances?

A Yes, I do.

Q And what is your opinion?

A He meets criteria for pedophilia, non-exclusive type, attracted to females; and he meets criteria for sexual sadism.

Q What is "pedophilia"?

A "Pedophilia" is a sexual attraction to prepubescent children. A guideline is given of about age 13, but people can reach sexual maturity at different ages. So it varies from case to case. That cause -- that last over a certain amount of time. The guideline is given of six months, but that's just to show a pattern, that it wasn't just someone got high on PCP and looked at child pornography one night. I mean, it's a pattern and it causes problems for them.

Q And what are the indicators or what evidence did you review that shows that the defendant meets the diagnostic

criteria for pedophilia?

A Well, he's viewed child pornography since 2011, at least. So we have the six-month criteria is easily met, 2011 through 2015.

He was convicted of conspiring to meet with an eleven-year-old girl for sex.

I viewed the child erotica that he was looking at. I don't know if you want me to describe that at this point or not.

Q What did it depict?

A Well, it was -- it was prepubescent children in underwear or, I guess, sort of lingerie and they were in sexual poses. Some of the times they were nude, but they would have their hands over their chest. They didn't really have breasts, so I guess it was just their nipples, or they would have their panties partially moved to almost show their vaginas. So we have that from 2011 to 2015.

And the erotica was just what was seized on his computer. We have him convicted of planning to meet an eleven-year-old for sex, him talking about what he would do with the eleven-year-old sexually. He admitted to the F.B.I. that he found it titillating. Some of the statements that he made to the undercover agent about is she -- is she bald down there, or something to that effect; statements that he made of things that he would like to do to her as well as the fact

that, you know -- so the second criteria being does it cause problems for them in functioning. Well, he was -- he was convicted of that, and so, you know, he certainly meets criteria for the disorder.

Q Did you find evidence that the defendant has any other sexual deviancies?

A I did, yes.

Q And what is that?

A Sexual sadism.

Q What is "sadism"?

A "Sadism" is gaining sexual arousal from the humiliation of the victim, inflicting of pain, seeing fear, feeling the power and control, things like that, in a sexual situation such that -- and then it goes on to say, you know, it causes problems for them and has existed for a period of time, so is therefore a pattern.

Q What evidence did you see in the record that the defendant has a diagnosis of sexual sadism?

A He admits in several different places to an interest in violent sexual encounters, forcing others to have sex with him. The transcripts with other Craigslist users and the undercover agent are quite graphic in his descriptions of what he wanted to do to the victim, Michelle.

And then we also have the B.D.S.M. pornography that was collected from his computers, which I viewed, which depicted

vary graphic scenes of rape and torture of a sexual nature of older females and younger females.

Q How many times have you diagnosed sexual sadism and pedophilia in the same individual?

A Never.

MS. REYES: Object to improper bolstering.

THE COURT: "How many times have you diagnosed sexual sadism and pedophilia in the same individual?" The objection is bolstering. I'm going to overrule the objection and allow the question to be answered.

A Never.

Q How does -- do these -- within the defendant, as you viewed the evidence, do these two sexual deviancies that he has, do they exist in a vacuum?

A No, they do not.

Q And how -- what evidence do you have of that?

A Well, we have no evidence that he is sexually attracted to adult females only when he's inflicting pain, rape and torture on them, but with children, he wants a nice, sweet relationship. I mean, there's nothing to indicate that.

In fact, the evidence that is present indicates that the two paraphilias sort of intersect and cross. He talks with the undercover agent about getting the adult victim together with the eleven-year-old female and letting them do things together. So we see what we usually see when there's lots of

different types of sexual deviance. We see a crisscross and an intermingling of the two.

Q Do you have an opinion as to why the defendant obsessed on the victim, M.O., in this case, Michelle?

A I do.

MS. REYES: Objection to speculation.

THE COURT: What's the response?

MS. GABLE: Your Honor, he's testifying as an expert. I'm asking him for an opinion. It will then be tied up to his overall risk assessment of this defendant.

THE COURT: I'm going to overrule the objection.

A Based on the description of the victim that I received in the record, she appears to be rather innocent, maybe even naive, sort of a soccer mom kind of individual, and this would speak exactly to his desire to dominate and control.

When we think of sexual attraction, we think of someone --

MS. REYES: Objection to non-responsive.

THE COURT: Overruled. Go on ahead and continue.

A -- we think of someone as being sexually attracted to another individual because of physical beauty or some kind of physical attraction; but when you're looking at something like sadism, you have to keep in mind that what constitutes the sexual attraction is the domination and the inflicting of pain and humiliation. So what better person than someone

that is that idyllic and rather Donna Reedish, if you will.

Q How does the fact that the defendant has both -- these two paraphilias that you've discussed, how does that affect your overall risk assessment of this defendant in terms of his risk to re-offend sexually?

A Sure. It increases his risk.

Q And how is that?

A Well, it increases his risk because it's further evidence of sexual deviance. And so when we're considering the two biggest risk factors, we're looking at antisociality and sexual deviance. So he has more sexual deviance than, say, someone who is strictly a pedophile or strictly a sadist.

And then, also, you have to look at a potential victim pool, and we already see evidence of that. He's not only capable of hurting children for sexual gratification; he's capable of hurting adults as well for sexual gratification. So that increases his risk in turn.

Q Dr. Turner, in reviewing the defendant -- or Dr. Sullivan's report, she indicated that the defendant tested on the Abel Assessment as being sexually attracted to adolescents ages 14 through 17, and then opined that that did not indicate sexual deviancy. Do you agree with that?

A No, I don't.

Q And why not?

A **There's some controversy about the Abel instrument. Fourteen to 17 is a night and day difference, and Abel says in the manual that it's prejudicial and it should not be considered abnormal.**

And I wouldn't say that it's abnormal for an adult man to be sexually attracted to a 17-year-old female. I would say that it's abnormal for a adult man to be sexually attracted to a 14-year-old female.

So I think to just chuck 14 and 17 as the same thing is inaccurate, and I think what should happen would be a follow-up period of questioning about, okay. Well, let's look. Is it 17 or is it 14?

Q **Did you see any indication that that follow-up was done in this case?**

A **No.**

Q **Is there, in fact, a D.S.M. diagnosis for sexual attraction to younger adolescents?**

A **It's not in the D.S.M., but there is a paraphilia entitled hebophelia, yes.**

Q **And what is hebophelia?**

A **Hebophelia is a sexual attraction to children, but children that are either peri-, so going through puberty, or post-pubescent, around twelve to 14.**

Q **Now, you also mentioned that the other predictor of recidivism is antisociality?**

A Correct.
Q What is "antisociality"?
A "Antisociality" is the presence of traits of entitlement; grandiosity; shallow affect, meaning not showing much of emotion; lack of remorse; lack of ability to empathize with other people; feeling entitled, that you're owed something; being willing to victimize other people; and then generally just irresponsible behavior, impulsivity, not taking responsibility for your own actions. It usually shows up in some sort of criminal history, substance abuse, unstable background, things like that.
Q Is there a test that psychologists administer to test antisociality?
A The P.C.L.R. is administered to assess for psychopathy. Antisociality and psychopathy are closely related, but they're not exactly the same thing.
Q Were you able to administer the P.C.L.R. in this case?
A No, I was not.
Q And why not?
A Well, I didn't interview the -- Mr. Gillis in person. And sometimes there's enough information and the A.P.A. ethical guidelines even account for conducting forensic evaluations without an interview just because it happens so frequently, and sometimes there's enough information to score based on the records and other interviews that may have

occurred, but in this case I didn't feel that ethically I could provide a total score based on the information that I had.

Q And was the information that you had primarily in the report of Dr. Sullivan?

A About his background and history, yes, ma'am.

Q What other kind of information would you have sought from Mr. Gillis?

A Well, in a psychosexual risk assessment I would want to ask about anything that would lead to a diagnosis of Antisocial Personality Disorder. I would want to know whether he played with fire as a child. I would want to know whether he hurt animals for fun. I would want to know whether he shoplifted. I would want to know whether he was truant, was he suspended, was he expelled from school, what kind of things was he in trouble for, was he a bully, was he in physical altercations.

I would want to know about his school history, why he left the different schools, why there was a ten-year period between different schools, what he did during those ten-year periods.

I would want to know more about his activity with prostitutes. He admitted to sexual activity at least six times with prostitutes. That wasn't really followed up.

I would want to know more about the period of arrest and

being pursued by law enforcement and placed on probation. I would want to know if he completed that probation successfully.

I would want to know more about his substance use history and then his sexual history. That's really what we're here for. So I would want to know about his masturbation habits, when he first looked at pornography, how often he looked at pornography, what were his preferences when he masturbated, just a lot of detail that wasn't available in the report.

Q Based on the evidence that you reviewed, did you see evidence that Mr. Gillis possesses characteristics of antisociality or associated with antisociality?

A Yes, I did.

Q And what is that? What evidence did you see?

A He does have a criminal history. He was arrested for D.U.I. in 1985. He was placed on probation in 1989 after evading arrest for a period of time.

You know, we -- in my review of the testing materials and his responses, he was quite dishonest about numerous things that were contraindicated by his interview with the F.B.I., for example, and his activity online.

You know, his statements about what he wanted to do to the victim, the fact that he had ridden in the car with the victim's children but was still planning all this, put her

picture out there, her name, that's evidence of callousness and a lack of ability to empathize.

You know, I -- I asked you -- at one point during our discussions I told you what I imagined his presentation on the stand --

MS. REYES: Objection, Your Honor, to speculation.

MS. GABLE: I'll cut this off. Thank you, Your Honor.

THE COURT: All right. I'll sustain it, then.

BY MS. GABLE:

Q Did you review the defendant's testimony and the direct and cross-examination of the defendant's trial testimony?

A Yes, I did.

Q And in reviewing that testimony, did you see any indicators of lack of empathy or callousness?

A Yes, I did.

Q And what was that?

A It was the -- his general response pattern. He seemed rather glib. There wasn't any expression of remorse that I saw.

He referred to the victim as "the MILF" repeatedly. So that's a depersonalization. So that's -- that's evidence of the personality construct, at least, of antisociality, psychopathy, conning, manipulation, failure to accept responsibility for his own actions.

Q **Did you see any evidence that he was irresponsible in his life?**

A **I did, yes.**

Q **What was that?**

A **Well, he had a pretty extensive history of substance use, cocaine, marijuana, alcohol, and then some that the report said he refused to reveal what they were.**

I know that there was one job that some of the records indicated he was fired from for anger.

His history of relationships is unstable. By his own report, in the report to Dr. Sullivan he says that he looks back on his life as failure after failure after failure after failure.

He does have an arrest history. He does have a history of anger. He does have a history of anger outbursts.

He admitted to missing work at times due to substance abuse, drinking, things like that. All of that is evidence of irresponsibility. And that's only what I was able to glean without an interview, based on the records.

Q **You've mentioned the term "protective factor" earlier in your testimony. What is a "protective factor"?**

A **A "protective factor" is something that can lower a person's risk of re-offending.**

Q **Did you see any evidence of a protective factor or any protective factors in this case?**

A I did, with -- with a caveat, yes.
Q And what was that?
A His age. Generally, a relatively older offender represents a younger -- I'm sorry -- represents a lower risk of re-offending than a younger offender; but the caveat is that that's generally reserved for someone that offends very young, serves a period of time, and then is released as an older individual.

But in this case that's mitigated. The protective nature of his age is mitigated by the fact that these offenses just occurred and all signs indicate that his behavior and fantasies and degree of violence was actually escalating.
Q And what is it that you saw in the record that indicated that?
A The pornography, the fact that he had progressed from viewing pornography to seeking out others online, to actually planning to meet, to actually showing up to meet, that he had engaged in specific behaviors to facilitate the abduction of Michelle, such as looking over her shoulder and seeing her phone pin, knowing her schedule, posting that online. So those would be some examples.
Q How does the evidence of his escalating behaviors affect your risk assessment of the defendant in this case?
A Well, it speaks directly to his risk assessment. He has

engaged in these behaviors over a period of many years, and he's escalating in his intensity and degree of violence and what he's willing to do that is illegal in order to satisfy those sexual urges.

In Dr. Sullivan's report, she also indicates that due to erectile dysfunction, he has to seek more arousing pornography. I find it concerning that the "arousing pornography" that he's seeking is more and more violent pornography, leading up to the subsequent offenses that he's been sentenced for.

Q Thank you, sir. I have no further questions.

THE COURT: Ms. Reyes, cross-examination?

MS. REYES: Yes, Your Honor.

CROSS-EXAMINATION

BY MS. REYES:

Q Dr. Turner, when were you retained by the government in this case?

A I believe it would have been sometime in the summer or late spring. I don't have an exact date.

Q Do you have an exact month?

A No.

Q Do you -- did you know, based on all of the documents that you looked at in this case, that he was convicted in May of this year?

A I'm sure I read that at some point, yes.

Q **And that sentencing in this case was set for August of this year?**

A **Yes.**

Q **And that a continuance was granted so that you could conduct an evaluation of my client? A two-month continuation was granted in this case so that you could conduct an evaluation of my client; did you know that?**

A **No, I was not aware of that.**

Q **Okay. At any point did you ever ask me for permission to meet with my client?**

A **No.**

Q **How much have you been paid by the government in this case?**

A **I don't have an exact amount. I'd have to estimate it for you.**

Q **Have you been paid at all as of today, September 21, 2016?**

A **No.**

Q **Okay. And how many times have you testified for the federal government on the prosecution side?**

A **I've been retained or testified?**

Q **The question is: How many times have you testified for the federal government, prosecution side?**

A **I believe three times.**

Q **And what is the total amount of money that you have**

received from the Department of Justice for your services?
A I have no idea.
Q The latest publication that you have listed in your C.V. is the bulletin from last July, correct?
A Correct.
Q And this was an article that you published in connection with the Department of Justice?
A Correct.
Q And it's basically a how-to, debunking defense experts in sentencing proceedings for child pornography offenders?
A That's not how I would describe it, but I could see that you would see it that way.
Q Were you paid for that article?
A No.
Q So you did it pro bono?
A Correct.
Q Did you review the images that are -- that you're -- on direct examination that you're characterizing as child pornography?
A Yes.
Q And would it surprise you -- and that was mentioning the child pornography, that Mr. Gillis viewed it for over a five-year period, that was a big part of your assessment, correct?
A Correct.

Q However, those images are not child pornography, correct?

MS. GABLE: Your Honor, I'll object to that.

THE COURT: I would imagine the expert is in a good position to answer that question. Overruled. He can answer.

MS. GABLE: Well, he isn't a lawyer, Your Honor.

THE COURT: I understand and I'll take that into consideration.

MS. GABLE: Thank you.

A I think there are guidelines for attorneys, agents to consider things as child pornography, child erotica.

From my standpoint, as a source of sexual attraction, what I saw I would consider it child pornography.

Q Would it surprise you to learn that he was never charged with possession of child pornography?

A No.

Q The Abel Assessment that you testified on direct examination, you're actually not licensed to conduct that test, correct?

A No, I'm not licensed specifically by Abel, if that's what you mean.

Q Okay. So your concerns about it are you couldn't -- you couldn't have done the follow-up for it had you wanted to or taken the time to because you're not licensed for that, correct?

A No, that's not correct.
Q You're not licensed to do the Abel Assessment?
A Correct.
Q Okay. So the concerns that you've mentioned on direct examination to the government, you couldn't have followed up with them had you chosen to because you're not licensed to do the Abel Assessment?
A No, that's not correct.
Q Okay. To your knowledge, in your vast experience, the Abel Assessment is graded off site?
A Yes.
Q So it's objectively graded?
A Portions of it are objective. Portions of it are subjective because they're self-report.
Q And based on what you testified on direct examination, it has to be a totality of the circumstances of every single test, right?
A Correct.
Q Okay. Would you agree -- you're concerned about the Abel grouping 14 to 17 year olds, right?
A Yes.
Q Okay. Would you agree that 14 to 17 includes both prepubescent and post-pubescent?
A It's possible. People reach pubescence at different periods.

Q **Are you saying that you're able to tell a difference between a 14-year-old post-pubescent girl and a 17-year-old post-pubescent girl?**

A **Sometimes, I think. Sometimes not.**

Q **Are you challenging the foundation of the Abel Assessment Test?**

A **I'm challenging grouping 14 and 17 in the same group and saying they're the same thing. So if that means that I'm challenging the foundation, then that's fine.**

Q **And have you contacted Dr. Abel to tell him that his test is not valid?**

A **No. There's plenty of criticism in the research of his test already.**

Q **Have you published any articles or done any research on attacking the validity of the Abel Assessment Test?**

A **No, ma'am.**

Q **You testified on direct examination that Mr. Gillis has been fired from work for anger management purposes?**

A **Yes.**

Q **Were you privy to the Presentence Investigation Report in this case?**

A **No.**

Q **So your information was gleaned from a conversation with the prosecutor regarding that specific issue?**

A **Yes.**

Q Would it surprise you to learn that he's never, ever been fired from a job for anger management reasons?
A It wouldn't surprise me.
Q Okay. But you just testified to that on direct examination, right?
A I was told that, yes.
Q Okay. And you testified on direct examination regarding his unstable relationships, correct?
A Yes.
Q Okay. Would it surprise you to learn that he's had three relationships and all three have been long-term?
A No. I knew that.
Q Okay. But you would consider that to be unstable?
A The nature of his relationships, yes.
Q Okay. And what is the nature of his relationships that you find to be unstable?
A Well, one of them was with a married woman, one of them was with a 19-year-old when he was in his 40s. I mean, things like that.
Q Which one was the relationship with the married woman?
A The first. His first relationship.
Q Would you --
A Or one of his first relationships.
Q Would it surprise you to learn that that's absolutely incorrect?

A It would surprise me to learn that.
Q Okay. And as part of your investigation in this case, did you actually read his entire transcript that he testified at trial?
A No.
Q So you pick and choose what parts of the transcript to read?
A No.
Q What parts of the transcript did you read?
A I read portions of the transcript that were sent to me related to various parts of the offense conduct.
Q So this transcript was approximately 110 pages. You could not have read that since July of -- or since you were hired in the summer?
A I don't know -- I don't know how much of it I read. I read what I was sent.
Q Okay. You testified on direct regarding a paraphilic disorder that is not in the D.S.M., correct?
A Correct.
Q Okay. So if it's not in the D.S.M., would you agree with me that it's not relied on by actual professionals?
A No.
Q Okay. You testified that Mr. Gillis has lived a life of irresponsibility?
A Yes.

Q **Did you testify to that on direct?**

A **Yes.**

Q **Okay. Would you consider it irresponsible to take family members in when they have nowhere else to go?**

A **No.**

Q **Would you consider it irresponsible to have a job when you're 19 years old for 19 years?**

A **No.**

Q **Would you consider it irresponsible to have -- after that, to have a second career in the culinary industry?**

A **No.**

Q **Would you consider it irresponsible to take care of an ailing father prior to his demise?**

A **No.**

Q **Would you consider it irresponsible to completely uproot your entire life and travel from Illinois to Florida to accomplish that?**

A **No.**

Q **Would you consider it irresponsible to then, after the father dies, actually move permanently to Florida to care for an ailing mother?**

A **No.**

Q **Would you consider it irresponsible to help raise young women?**

A **I would consider it maybe concerning, in light of the**

offenses he was sentenced for.

Q Okay.

MS. REYES: May I have a brief moment, Your Honor?

THE COURT: Certainly.

BY MS. REYES:

Q You testified on direct examination that Mr. Gillis lied about substance abuse.

A I don't know if I said he -- if I did say he lied about substance abuse, I think -- I didn't mean to say he lied. He was just -- he wasn't completely forthright about it.

Q And where did you get that information?

A It's in the -- it's on the testing results, multiple testing results and his interview with Dr. Sullivan.

Q Would it surprise you to learn that in his interview with a United States Probation Officer sentencing guideline specialist, he was completely forthright about his substance abuse?

A No.

Q And his substance abuse is approximately 30 years old?

A No, that wouldn't surprise me.

Q And you testified on direct that you're very concerned about a D.U.I. that he got in 1985, correct?

A I said I'm concerned that he has a criminal history.

Q Which includes one D.U.I. from over 30 years ago?

A Correct.

Q That concerns you?
A Yes.
Q Okay. You testified on direct that one of the most effective ways to measure antisocial behavior is through the P.C.L.R.?
A Correct.
Q And you were very concerned about all these questions that weren't developed in Dr. Sullivan's report?
A Correct.
Q But you had access to her raw data, correct?
A Correct.
Q And all of those -- the checklist for this was properly administered by Dr. Sullivan, correct?
A I had a hard time reading the notes from her evaluation. I saw the score for the P.C.L.R. that she administered.
Q If you wanted to follow up, based on all of these concerns that you mentioned on direct, there was nothing stopping you from talking to my client, correct?
A That wasn't my understanding, no.
Q Was it your understanding that the government asked for a continuance in order for you to evaluate my client?
A No, that was not my understanding.
Q You testified on direct that Mr. Gillis has been viewing child pornography since 2011?
A Correct.

Q Where did you get that information?
A It was in the summary of his interview with the F.B.I.
Q Have you -- in your vast experience, have you learned of defendants not agreeing with what the F.B.I. agent attributes to them?
A Sure. Absolutely.
Q Okay. You had access in Texas or Louisiana -- you actually had access to all of the evidence in this case, correct?
A Yes.
Q Okay. Based on your view of the evidence, would it be fair to say that his viewing of what you term "pornography" was intermittent?
A Yes.
Q And it wasn't continuous for 2011 to 2015?
A Correct.

MS. REYES: Nothing further, Your Honor.

THE COURT: Thank you, Ms. Reyes.

Redirect examination?

REDIRECT EXAMINATION

BY MS. GABLE:

Q Dr. Turner, regarding the instability of the defendant's relationships, did you obtain the information that the defendant's first relationship was a married woman from the report of Dr. Sullivan?

A I did, yes.
Q And did you obtain the information that he was with a 19-year-old woman when he was 40 from the report of Dr. Sullivan?
A Yes, I did.
Q Dr. Turner, did you -- in the testimony that you reviewed from the trial, was it the direct and cross-examination of the defendant, Dane Gillis?
A Yes, it was.
Q Thank you. I have no further questions.

THE COURT: Thank you, Doctor. Feel free to be seated in the courtroom.

Will the government be calling any further witnesses at this time?

MS. GABLE: No, Your Honor. I do have a letter -- it's a very short letter -- to read from the victim to the Court.

THE COURT: Well, that was going to be my next question. Why isn't the victim here?

MS. GABLE: Your Honor, candidly, she was afraid.

THE COURT: All right. And she asked you to read that letter to the Court?

MS. GABLE: She did, yes.

THE COURT: All right. Feel free to read the letter.

Exhibit F

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Variables in Delayed Disclosure of Childhood Sexual Abuse

Eli Somer, Ph.D., and Sharona Szwarcberg, M.S.W.

In a study of 41 adult survivors of childhood sexual abuse, the level of childhood traumatization was found to have contributed to delayed disclosure of the abuse. Other delaying variables included: belief in the importance of obedience to grownups, mistrust of people, fear of social rejection, and fear of the criminal justice system. Variables such as media attention to similar cases and experiences of personal achievement were inversely related to the age at disclosure. Recommendations for policy are discussed.

A wide array of social, psychological, and somatic problems has been connected with childhood sexual abuse (CSA). These problems include sleep disorders, eating disorders, self-mutilation, social withdrawal, antisocial behavior, sexual dysfunction, injured sense of self, and disorders of attachment *(Bagley & Ramsay, 1985; Briere & Runtz, 1989; Browne & Finkelhor, 1986; Cohen & Mannarino, 1988; Finkelhor, 1987; Herman, 1981; Roth & Lebowitz, 1988; Young, 1992)*. The consequences of undetected abuse compound the immediate trauma in child victims and are associated with grave developmental outcomes typically characterized by impaired capacities for trust, intimacy, and sexuality, and by a variety of chronic mental health problems.

Despite the pain associated with childhood abuse, early confiding of intrafamilial maltreatment is fairly rare, and often meets with adverse responses *(Everill & Waller, 1995)*. Herman *(1992)* stated that the main dialectic of emotional trauma is the conflict between the need to deny unbearable experiences and the need to give testimony. The literature suggests that the majority of children do not disclose until adulthood *(Lamb & Edgar-Smith, 1994)*, if at all *(Sauzier, 1989)*; that up to 40% of adult survivors had never disclosed their secret before data were collected *(Finkelhor, 1987)*; that the average age at disclosure of incest is 25.9 years *(Roesler & Wind, 1994)*; and that 22% of disclosing survivors did so at least 15 years following their last incident of sexual abuse *(Somer, 1995)*. Personal accounts of CSA experiences by adult survivors mark a potential shift in the survivors' ability to form a trusting relationship with another human being *(Harvey, Orbuch, Chwalisz, & Garwood, 1991)*. For people who suffered CSA, confiding may signal the beginning of a move from the role of silent victim to that of indignant survivor.

Because early disclosure by victims may serve to ameliorate the destructive relationship and mitigate the deleterious effects of prolonged abuse, we designed this study to identify empirically those variables associated with delayed disclosure of CSA. We constructed a research instrument to assess retrospectively those changes in survivors' life circumstances and beliefs that might help to explain their leap from secrecy to testimony. First, we generated a list of potentially relevant factors and searched the literature for supportive evidence. Presented below are the variables that seemed pertinent. We have distinguished between variables that potentially delay disclosure (coded "D") and those that potentially facilitate it (coded "F").

A revised version of a paper submitted to the Journal in October 2000. *Authors are at: School of Social Work, University of Haifa, Israel (Somer); and Department of Education, Ben Gurion University of the Negev, Be'er Sheba, Israel (Szwarcberg).*

Based on our review of the literature and our own clinical experience, we identified four categories of variables pertinent to the withholding or disclosure of CSA. These consisted of: *1)* ten psychological variables, associated with victims' intrapsychic processes: *2)* five familial variables, associated with interpersonal processes within the family; *3)* four social variables, associated with societal norms and influences; and *4)* one trauma-related variable. These are listed, coded, and briefly defined in the following four sections.

Psychological Variables

Accommodation (D). Some professionals have suggested that the pathological environs of the abusive family force the child to develop unusual coping strategies that are both creative and destructive *(Herman, 1992; Summit, 1983)*. Victims of CSA learn to distort their oppressive reality and to deny the perversion they are subjected to by regarding it as acceptable and normal.

Guilt and self-blame (D). Several studies of the long-term effects of CSA have reported guilt as a common reaction of survivors *(Browne, 1991; Coffey, Leitenberg, Henning, Turner, & Bennett, 1996; Goodwin, 1989; Finkelhor, 1987)*. Briere *(1992)* suggested that children's mode of thinking about the world could give rise to an "abuse dichotomy," in which they attribute their incestuous injury to one of only two things: either they have been bad or their parent has been bad. Guilt and self-blame by CSA victims have been seen as instrumental in preserving the relationship with abusive caregivers *(Price, 1993)* and as in keeping with children's self-centered perspectives *(Herman, 1992)*.

Helplessness (D). Bagley and King *(1989)*, using Seligman's theory of learned helplessness, noted that CSA can induce feelings of powerlessness and a subsequent decrease in responsiveness. According to James *(1989)*, because many children feel that there is nothing and no one able to protect them or halt their abuse, the ensuing sense of powerlessness pervades their self-image. These assertions are supported by other clinical and research reports *(Coffey et al., 1996; Liem, O'Toole, & James, 1996; Shapiro, 1996)*.

Emotional attachment to the perpetrator (D). Survivors of CSA develop intense, tenacious attachments to abusive others. Object-relations and attachment theories have been used to explain the need of survivors to preserve the self and the attachment to the abusing caretaker. To satisfy that need, abused children employ several defenses, including splitting, dissociation, and idealization *(Blizard, 1997a, 1997b; Blizard & Bluhm, 1994)*. When a child idealizes an object, it is preserved as good, and the child can safely maintain a positive attachment to it. To do so, the child often also needs to displace the blame for the abuse onto the self and to devalue it *(Kernberg, 1975)*. Preservation of the self may also take the form of identification with the aggressor, involving an attempt to empower oneself at a time of utter helplessness *(Freud, 1966)*. A similar paradoxical phenomenon, termed "the Stockholm syndrome," describes the development of reciprocal, positive feelings between hostages and their terrorist captors, as a means of coping with captivity *(Auerbach, Kiesler, Strentz, Schmidt, & Serio, 1994; Graham et al., 1995)*.

Idealized self-identity (D). Price *(1993, 1994)* suggested that some abused children replace their helplessness with an illusionary sense of control and omnipotence, an adaptive mechanism utilized to cope with a traumatic and pathological situation and provide them with a sense of self-worth.

Mistrust of others (D). Green *(1996)* described paranoid reactions and mistrust as core sequelae of CSA. Given the mistreatment by their caretakers, sexually abused children may come to believe that there is little chance of strangers offering greater protection *(Finkelhor, 1987; Herman, 1992)*.

Dissociation (D). Early links between history of trauma and dissociation have been documented in several studies *(Carrion & Steiner, 2000; Somer & Weiner, 1996; Zlotnick et al., 1996)*. Sexually abused children commonly use dissociation of affect to protect themselves from overwhelming emotions, thoughts, and sensations, thus decreasing awareness of their abusive circumstances.

Burden of the secret (F). Some survivors who no longer feel dependent on the perpetrator have a need to break their silence and relieve themselves of their secret. A study of incest survivors' narratives of their process of disclosure *(Mize, Bentley, Helms, Ledbetter, & Neblett, 1995)* found that feelings during or immediately following disclosure included relief and a sense of reconnection with others.

Successful/ego-strengthening experiences (F). Feelings of empowerment are among the emotions reportedly engendered by the act of disclosure *(Mize et al., 1995)*. However, empowering experiences can also be antecedents to disclosure. Our

own clinical work indicates that successful academic or professional experiences can provide a much-needed sense of mastery and competence, which may evolve into the enabling processes necessary for disclosure of the incestuous secret.

Concern for others (F). Many CSA survivors exhibit concern for the well-being of younger family members. Whereas accommodation, guilt, and self-blame may initially keep these victims silent, once their abuse ends, many seek to unmask the perpetrator out of fear that younger relatives may be in jeopardy. An analysis of the annual reports of the Union of Rape Crisis Centers in Israel revealed that 11% of CSA victims who phoned in for help were motivated by concern for other at-risk children *(Somer, 1995)*.

Family Variables

Loyalty to the family (D). The degree of familial closeness between victim and abuser seems to be another relevant variable in predicting loyalty to the perpetrator and maintenance of secrecy. The more enmeshed the family, the closer the kinship with the abuser, the more severe the abuse, the more difficult the disclosure is reported to be *(Chen, 1996; Faust, Runyon, & Kenny, 1995; Mennen-Ferol, 1993; Wyatt & Newcomb, 1990)*.

Cultural norms reinforcing obedience (D). Radical feminist theory holds that patriarchy is related to the oppression and victimization of women. Solomon *(1992)* argued that this theoretical framework could be used to understand children as victims of sexual abuse by family members. Others have concurred that the sociopolitical and cultural contexts in which children are raised provide a frame of reference for the internalization of oppression and victimization through sexual abuse *(Comas-Diaz, 1995; Fontes, 1993, 1995; Okamura, Heras, & Wong, 1995)*.

Concern for family integrity (D). Perpetrators of CSA and incest use a variety of techniques to threaten, persuade, and manipulate their victims, so that the sexual encounters are kept secret. Prominent among these are manipulative warnings that disclosure will lead to the dissolution of the family *(de Young, 1981; Ussher & Dewberry, 1995)*.

Conservative sexual morality (D). The dynamics of sin and shame, and the lack of family idioms with which to discuss sexual behavior, characteristics common to very conservative communities, could contribute to CSA victims' difficulties in disclosing their plight *(Carbo & Gartner, 1994)*. In many cases of incest, abusive fathers have been reported to be men who are devout, moralistic, and fundamentalist in their religious beliefs *(Hoorwitz, 1983; Hudson, 1996; Manlowe, 1995)*.

Fear of blame (D). Sexually abused children seem to be able to assess accurately the outcome of their disclosure. Lawson and Chafin *(1992)* found that the tendency of children afflicted with venereal diseases to disclose sexual abuse was predicted by the attitudes of their family members, who were independently assessed prior to the interview with the child. The outcome of childhood disclosure of CSA is often met with disbelief, denial, or blame *(Mize et al., 1995; Roesler & Wind, 1994)*.

Social Variables

Rejection and avoidance of victims (D). Victims are frequently perceived as weak, passive, and at least partially responsible for their tribulations. Staley and Lapidus *(1997)* found that subjects who did not know an incest survivor personally were significantly more likely than those who did to agree with victim-blaming statements. Reactions to survivors' initial revelations include indifference, skepticism, negative or rejecting responses, and blame *(Armsworth, 1989; Friese, Hymer, & Greenberg, 1987; Flannery, 1990; Gurley, 1991; Harter, Alexander, & Neimeyer, 1988)*. The inclinations of CSA victims to share their pain with others could be influenced by this perceived atmosphere.

Stigma (D). Survey responses from 195 college students indicate that there is a stigma surrounding CSA that varies with gender and with length and type of relationship at the time of the disclosure *(Tomlin, 1991)*.

Mistrust of the judicial system (D). Prevailing attitudes toward rape and rape victims are often mirrored in the legal and judicial systems. Survivors of sexual assault frequently complain that their experience with the criminal justice system was humiliating. Inappropriate sexual interest, derogatory questioning, and a generally disrespectful attitude often mark the process *(Krieger & Robbins, 1985; Mazelan, 1991)*.

Publicity in the media (F). Beckett *(1996)*, in a content analysis of reports on sexual abuse in four leading news magazines between 1970 and 1994, found that the framing of CSA in media discourse has undergone a significant transformation. With increased media attention to personal and social costs of CSA, violence against children has been

steadily moving out of the shadows and into the arenas of research, prevention, intervention, and public awareness *(McDevitt, 1996; Roesler & Wind, 1994)*.

Trauma-Related Variables

Intensity of traumatization (D). Children's failure to report their sexual victimization may be due to their being overwhelmed by the objective weight of these harmful experiences. The level of traumatization and the ensuing psychological damage have been attributed to: early onset of the abuse *(Zivney, Nash, & Hulsey, 1988)*, its duration *(Elliot & Briere, 1992; Herman & Schatzow, 1987)*, the age difference between victim and abuser *(Finkelhor, 1987)*, the number of perpetrators *(Peters, 1988)*, the intrusive level of the abuse *(Finkelhor, Hotaling, Lewis, & Smith, 1989)*, and the number of different types of abuse *(Briere & Runtz, 1989; Henschel, Briere, Magallanes, & Smiljanich, 1990; Elliot & Edwards, 1991)*.

METHOD

Study Aims and Hypotheses

This study sought to examine whether any of the potential variables believed to be affecting the likelihood of disclosure of CSA were related to the age at which the secret was first revealed. It was posited that: *1)* The burden of the secret; successful and ego-strengthening experiences; concern for the safety of others; and publicity in the media (i.e., the facilitating variables) would be associated with increased likelihood of disclosing the incestuous secret, while all the other variables reviewed (the delaying variables) would be negatively related to the chances of early disclosure. *2)* Variables classified as facilitating would be rated as having had more subjective validity during the time immediately following the disclosure of abuse, whereas delaying variables would receive a higher ranking for the period that preceded the disclosure. *3)* Trauma scores would be positively related to respondents' age at disclosure and to delaying variables.

Subjects and Procedure

Volunteers and therapists in ten Israeli rape crisis centers and clinical institutions specializing in the treatment of sexual abuse trauma were asked to solicit the participation of Hebrew-speaking clients who were not suffering from any acute emotional condition. This was, therefore, a convenience sample, deliberately recruited from a small population. Forty-one survivors of CSA, who were assessed by their caretakers as having regained sufficient emotional stability to partake in this study, consented to participate. Very few recruits declined the invitation; the response rate was near-perfect. The anonymous research questionnaires were returned directly to the investigators via stamped, self-addressed envelopes included in the research packages. Thirty-nine respondents were women, two were men. Their mean age was 32 years (range: 16–56; *SD*=9.46). They had an average of 14 years of schooling (range: 6–20; *SD*=2.71). Thirty-seven percent of the participants had never married, 34% were divorced, and 29% were married.

Instruments

Child Sexual Abuse Delayed Disclosure Checklist

The CSADDC was designed by the present authors to assess variables associated with the likelihood of disclosure of CSA. The instrument was constructed in the following way. Six statements were generated for each of the 19 variables comprising the psychological, familial, and social variable categories. (The single trauma-related variable was assessed by means of a separate instrument, as noted below.) For example, the variable of "guilt and self-blame" was assigned such statements as: "I feel guilty about what happened to me" and "I should have behaved differently."

In the next stage, the 114 statements were validated in a series of steps. First, all the statements were written down on numbered cue cards. Ten Hebrew-speaking, university-educated adults were asked to sort them based on best conceptual fit with the 19 variables. The degree of agreement between the researchers' classification and that of the raters, as well as the interrater agreement, was noted for each statement. For example, if the statement "I am a weak person" was identified with the "helplessness" variable by nine of the ten raters, interrater agreement was 90%.

The second step in the validation procedure involved the use of a questionnaire containing the 19 variables, each with its six statements listed below. Twenty-six Hebrew-speaking, university-educated adults who had not participated in the prior step rated the degree of agreement between each statement and the variable to which it was assigned, using a ten-point scale (1=does not describe the variable at all; 10=describes it very well). With mean agreement scores and standard deviations having

been calculated, statements were given standard scores; during the final validation phase, all statements were given two scores, then ranked in descending order of interrater agreement and standard score. Four statements were also added from the Dissociative Experiences Scale *(Carlson, 1997)*, two of them describing amnesia symptoms and two representing depersonalization symptoms. Ultimately, 42 statements comprised the items on the CSADDC.

Respondents were asked to rate the degree to which they identified with each statement on the CSADDC during two different periods: *a)* predisclosure, i.e., the period of the abuse and their keeping it secret; and *b)* immediately following disclosure. Rankings were based on a five-point Likert scale (1=Did not feel it/believe in it; 5=Felt it/believed in it very strongly). Potential total scores on the CSADDC for each reference period ranged from 42 to 210. Reliability measures for the CSADDC were calculated four times. Cronbach's alpha and split-half reliability procedures were performed on the CSADDC for each of the two periods: predisclosure (0.83 and 0.82, respectively) and following disclosure (0.75 and 0.70, respectively), revealing good internal consistency for the measurements performed for the first period and moderately good internal consistency for the second period.

Traumatic Experiences Questionnaire

The TEQ *(Nijenhuis, van der Hart, & Vanderlinden, 1998)*, later slightly modified and relabeled the Traumatic Experiences Checklist *(Nijenhuis, 1999)*, is a self-report questionnaire inquiring about 25 types of interpersonal and noninterpersonal life events that could be potentially traumatic. When interpersonal violence was explored, subjects were asked to indicate if immediate family members, relatives, or others hurt them. TEQ items ask whether respondents had suffered from the following stressors: parentification (a child needing to act in a parental role), major loss (e.g., death of a loved one), life-threats, traumatic life events, emotional neglect, emotional abuse, physical abuse, sexual harassment, or sexual abuse.

The TEQ specifically addresses the subjective impact of the event (i.e., how traumatic was it for the respondent), and also elicits information on the number of perpetrators of emotional, physical, and sexual abuse. The questions contain short descriptions aimed at defining the events of concern. All items are preceded by the phrase: "Did this happen to you?" For example, a TEQ sexual harassment item is: "Sexual harassment (acts of a sexual nature that *do not* involve physical contact) by your parents, brothers, or sisters." Similarly, a sexual abuse item is: "Sexual abuse (unwanted sexual acts involving physical contact) by your parents, brothers, or sisters."

Moderate to strong associations of the TEQ total score and composite scores, in particular physical and sexual abuse, with current psychological and somatoform dissociation supports the construct validity of the TEQ. These associations were found when studying psychiatric outpatients with dissociative and other mental disorders *(Nijenhuis, Spinhoven et al., 1999)*, and gynecology patients with chronic pelvic pain *(Nijenhuis, Van Dyck et al., 1999)*.

Among the key factors defining an event as traumatic are: perception of the event as having highly negative valence *(Carlson, 1997)*, multiple perpetrators *(Peters, 1988)*, duration and frequency of the abuse *(Elliott & Briere, 1992)*, and abuse at an earlier age *(Zivney, Nash, & Hulsey, 1988)*. The TEQ composite trauma score reflects these relevant traumatogenic factors. Each experience identified as a trauma item was given one point. Subjects could score 0–3 trauma points, depending on the number of perpetrating sources. Additional points were given to each personal trauma score if the subject was younger than age ten when traumatized, if the trauma lasted more than one year, and if the impact of the traumatic event was rated as 4 or 5 on a five-point subjective severity scale. Personal trauma scores in each of the nine categories ranged from 0–7. Composite personal trauma scores ranged from 0–63.

Personal Data Questionnaire

The PDQ includes 17 items, incorporating sexual trauma-related questions adapted from King et al. *(1995)*. Subjects were asked open- and closed-ended questions that included items regarding the circumstances in which they had first become aware of the abuse, the reactions they received following their disclosure, and the meaning of the disclosure in their lives. The PDQ also yielded a sexual traumatization score that reflected the frequency, age at onset, and termination of the abuse (range 6–15). In addition, there were items designed to assess variables such as sex, age, level of education, marital status, and country of birth, and

questions pertaining to the age at and circumstances of the disclosure.

RESULTS

Circumstances of the Abuse/Disclosure

The average age of respondents in this study was 7.11 years (range: 1–15, *SD*=3.85) at CSA onset, and 14.08 years (range: 7–23, *SD*=4.14) when the abuse ended. They first became aware of having been victimized at an average age of 15.8 years (range: 5–39, *SD*=7.6) and were, on average, 22.08 years old when they first disclosed their secret to someone else (range: 10–46, *SD*=9.18). When asked about the circumstances of having become aware of CSA, 43% responded that they had always realized that what had happened to them was improper, 33% became aware that they had been abused following a significant triggering event associated with sexuality (e.g., sex education classes, sexual experiences, pregnancy), 9% realized something was wrong following a direct question from a family member, 9% following a direct question from a therapist, and 6% became spontaneously aware of their abuse during psychotherapy. TABLE 1 describes the distribution of perceived reactions of study respondents by age at disclosure.

In all cases but one, disclosure to the mother elicited a hostile/indifferent reaction; further, 95% of respondents chose to disclose to a nonfamily member. A content analysis of responses to the question regarding the meaning of the disclosure and its outcome revealed that none of those who had disclosed during childhood perceived the disclosure as having had a positive impact on their lives (e.g., "The reaction I received silenced me until I was 46 years old"). The older the survivors were at the time of disclosure, the more likely they were to report a positive outcome. For example, 73% of those who first disclosed during adulthood felt the experience to be positive (e.g., "I understood it wasn't my fault" or "It was only after the disclosure that I realized I deserved to heal").

Table 1

PERCEIVED SUPPORTIVE AND HOSTILE/INDIFFERENT REACTIONS FOLLOWING CSA DISCLOSURE BY AGE AT DISCLOSURE

AGE	REACTION	*N*
9–12 Years	Supportive	0
	Hostile/indifferent	5
13–18 Years	Supportive	6
	Hostile/indifferent	7
19–46 Years	Supportive	19
	Hostile/indifferent	3

Delaying and Facilitating Variables

The correlation coefficient of the mean composite CSADDC score for the delaying variables and the age at disclosure of the abuse was .35 ($p<.05$). Items related to familial variables had a correlation of .29 with age at disclosure ($p=.06$). A closer analysis of relationships between specific items and age at disclosure revealed that statements about the importance of obedience to grownups ($r=.31$, $p<.05$) contributed most to this finding.

Psychological variables showed a correlation of .31 ($p=.05$) with age at disclosure. Among the items comprising this cluster, those that contributed most to this relationship were statements about mistrust of people ($r=.25$, $p=.05$), a sense of helplessness ($r=.24$, $p=.06$), and amnesia ($r=.22$, $p=.08$). Social variables showed the most powerful effect on CSA disclosure ($r=.45$, $p<.005$). Fear of social rejection ($r=.31$, $p<.05$) and fear of being condemned by the criminal justice system ($r=.32$, $p<.05$) were the items most strongly related to an older age at disclosure.

The mean composite score for the delaying variables was 3.75 (*SD*=.62) for the predisclosure period, and 2.76 (*SD*=.76) for the time immediately following. This difference was significant ($p<.001$), thereby providing further validation for the delaying valence of these items.

The correlation coefficient of the mean composite CSADDC score for the facilitating variables and age at disclosure of CSA was -.36 ($p<.05$). The items contributing most to this result related to publicity in the media of similar cases ($r=-.34$, $p<.05$), experiences of personal achievement ($r=-.33$, $p<.05$) and concern for the welfare of other potential victims ($r=-.22$, $p=.09$). Mean score for the facilitating variables was 2.63 (*SD*=.97) for the predisclosure period and 3.70 (*SD*=.67) postdisclosure. This difference was significant ($p<.001$), thereby providing additional validation for the facilitating valence of these items. These results confirmed our first and second research hypotheses.

Trauma and CSA Disclosure

Forty-nine percent of respondents had experienced all five major abuse categories (emotional neglect, psychological abuse, physical abuse, sexual harassment, and sexual abuse). Emotional neglect and psychological abuse had been experi-

enced by 90% of the respondents, and 54% had experienced physical abuse in addition to their sexual victimization.

The composite trauma score (TEQ) was correlated with age at CSA disclosure at a level of .30 ($p<.05$). Specific trauma experiences that showed the strongest relationship with an older age at disclosure were emotional neglect ($r=.39$, $p<.05$) and sexual harassment ($r=.33$, $p<.05$). The TEQ also showed a highly significant relationship with the mean composite CSADDC score for the delaying variables ($r=.43$, $p<.001$). Among the specific trauma categories, those that showed the strongest relationship with delayed CSA disclosure were psychological abuse ($r=.49$, $p<.001$), emotional neglect ($r=.36$, $p<.05$), and sexual abuse ($r=.36$, $p<.05$). These findings confirmed our third research hypothesis.

To investigate further the relationship between traumatic experiences, delaying variables, and facilitating variables and the age at disclosure of CSA, a hierarchical multiple regression was performed (see TABLE 2). The order of the steps was hypothesis-driven, while the criterion for a variable entering the equation at each step was set at $p<.05$. In the first step, the composite TEQ score was entered. In the second step, we entered the mean composite CSADDC score for the facilitating variables, $R=.52$, $R^2=.27$, $F(2, 38)=7.04$, $p<.005$. The mean composite CSADDC score for the delaying variables did not meet the required significance criterion.

DISCUSSION

This retrospective study explored the circumstances and experience of CSA disclosure and the relationships among level of childhood traumatization, disclosure variables, and age at disclosure. Although no claim can be made that our research sample was representative of all victims of CSA in Israel, it seems reasonable to suggest that these respondents are representative of the adult population of clients seeking help for CSA-related psychopathology in our country.

Several important findings emerged. Respondents in this study had first been molested when they were about seven years old; more than 8.5 years elapsed before they became aware of their maltreatment; and more than six additional years (close to 15 years since the onset of the abuse) elapsed prior to the disclosure of their ordeals. None of the respondents had ever filed a complaint against their perpetrators. These findings underscore the problems of delayed reporting and underreporting of CSA. They validate previous Israeli findings *(Somer, 1995)* and are in line with North American reports *(Lamb & Edgar-Smith, 1994; Wyatt, Tamra, Beatriz, Carmona, & Romero, 1999)*.

Roesler and Wind *(1994)* noted that when children told about abuse, they were most likely to tell adults in their family. By contrast, most of the respondents in the present study disclosed to nonfamily members. The few who had disclosed within the family reported an indifferent or hostile reaction. Among factors that contributed prominently to the delayed disclosure were fears of social rejection and condemnation, mistrust of people, and adoption of family-indoctrinated values of obedience. These variables represent perceived concentric circles of social disbelief, incomprehension, and oppression that had stifled motivation to disclose.

These respondents' tribulations started some 25 years before data were collected and ended 16 years prior to their being surveyed. Victimization, therefore, occurred before recent changes in Israeli public awareness about CSA and prior to local legislation of mandatory reporting laws. Whether or not sexually abused children in Israel are currently disclosing their abuse at an earlier age and are being met with more supportive reactions remains a research question to be investigated.

Ninety percent of the respondents also reported having been psychologically mistreated. A major factor involved in delayed reporting of CSA was the extent of concomitant childhood traumatization. Delaying variables did not add significantly to the explanation of delayed reporting beyond the contribution of the composite trauma score. We believe that the psychological battering of these children may have weakened their ability to view

Table 2

HIERARCHICAL REGRESSION OF TRAUMATIC EXPERIENCES, DELAYING VARIABLES, AND FACILITATING VARIABLES ON AGE AT DISCLOSURE

VARIABLES	*B*	SE *B*	*β*
Step 1			
Traumatic Experiences	1.45	0.61	0.36*
Constant	13.66		
Step 2			
Facilitating Variables	-3.47	1.27	-0.38**
Traumatic Experiences	1.60	0.56	0.38**
Constant	22.22		

*$p<.05$; **$p<.01$.

themselves as worthy of benevolent care, and severely damaged their capacity to trust adults.

The present data suggest that the variable of media attention was positively associated with disclosure of CSA. This supports our clinical experience and involvement with local rape crisis centers, where we have seen that high-profile media attention to CSA is typically followed by a surge of phone calls and requests for help from people who had never before revealed having been abused. This finding has important implications for research, since little is known about the effects of media campaigns targeted at young, high-risk populations. Still, media campaigns alone are unlikely to help children overcome the oppressive forces that prevent disclosure. The present findings suggest that mistrust of adults (in particular adult family members) and anticipation of adverse response to disclosure were strongly related to the delayed disclosure by respondents. Child victims of sexual abuse, particularly intrafamilial abuse, may not be willing to sacrifice the integrity of their families and their sense of belonging to it.

Implications for Policy and Practice

Perhaps the key policy-related question raised by the present research is: "What can be done to promote early disclosure of CSA?" We suggest that children might be less reluctant to reveal their plight if they and their families believed that rehabilitative sentencing were an option. The dilemma of choice between a rehabilitative and a punitive model in sentencing CSA and incest offenders has recently been addressed in the literature *(Fox, 1999; Stone, Winslade, & Klugman, 2000)* and is currently being debated among Israeli child welfare policy makers. Family therapy for victim and offender in cases of father-daughter incest was endorsed in earlier clinical reports *(Eist & Mandel, 1968; Hoorwitz, 1983; Madanes, 1990; Meiselman, 1990)*. However, in the absence of immédiate legal sanctions, incestuous families show a tendency to avoid therapy *(Byrne & Valdiserri, 1982)*.

It may be instructive, in these cases, to think of the child survivor as having two main categories of therapeutic challenge: processing the sexual trauma itself and correcting the maladaptive family experience (including the ideas and values inculcated by the incestuous family). Treatment options as alternatives to incarceration of fathers who confess their incest could help victims disclose their secret earlier, and make it more likely that offenders will take responsibility for the pain they have inflicted. Early intervention in incestuous families, as an alternative to the incarceration of the offending parent, can enhance the prospect of the child benefiting from a healthier family environment.

Parallel programs to optimize the facilitating variables identified in this research should also be developed. Investing in preventive school-based programs is not only clinically wise but economically sensible. Suffering abuse puts children at greater risk for many difficulties throughout their lives. For example, it has been estimated that some 30% of abused children in the United States have some type of language or cognitive impairment; over 50% have socioemotional problems; 14% exhibit self-mutilative or other self-destructive behavior; over 50% have school difficulties, including poor attendance and misconduct; and 22% have a learning disorder *(Daro & McCurdy, 1991)*. Caldwell *(1992)* estimated that one-quarter of all children from abusive households will receive some special education services for at least one year between kindergarten and twelfth grade. If we add to this the costs of foster care, medical and psychological care, and juvenile justice services, the fiscal rationale for developing child-focused interventions designed to make children less vulnerable targets for abuse becomes self-evident. Caldwell further maintained that the costs of two types of prevention efforts—home visitor and parent education programs—were, respectively, 3.5% and 7.0% of the calculated costs of child abuse.

There is a need for child protective services and school counselors and administrators to plan public and school-based educational campaigns aimed at increasing awareness of children's needs and their rights to proper care; to teach children self-protective skills; and to provide a potential "safe haven" for these children, as well as a family rehabilitative option for the courts to consider. Even the most effective prevention programs may not eliminate entirely the scourge of childhood sexual abuse. Still, modest steps in this direction can bring huge benefits to children and to society.

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Exhibit G

Brief Communication

Prevalence of Childhood Sexual Abuse and Timing of Disclosure in a Representative Sample of Adults From Quebec

Martine Hébert, PhD[1,2]; Marc Tourigny, PhD[2,3]; Mireille Cyr, PhD[2,4]; Pierre McDuff, MSc[5]; Jacques Joly, PhD[3]

Objective: Our study sought to explore patterns of disclosure of child sexual abuse (CSA) in a sample of adult men and women.

Method: A telephone survey conducted with a representative sample of adults (n = 804) from Quebec assessed the prevalence of CSA and disclosure patterns. Analyses were carried out to determine whether disclosure groups differed in terms of psychological distress and symptoms of posttraumatic stress, and a logistic regression was used to examine factors associated with prompt disclosure.

Results: Prevalence of CSA was 22.1% for women and 9.7% for men. About 1 survivor out of 5 had never disclosed the abuse, with men more likely not to have told anyone, than women. Only 21.2% of adults reported prompt disclosure (within a month of the first abusive event), while 57.5% delayed disclosure (more than 5 years after the first episode). CSA victims who never disclosed the abuse and those who delayed disclosure were more likely to obtain scores of psychological distress and posttraumatic stress achieving clinical levels, compared with adults without a history of CSA. In the multivariate analysis, experiencing CSA involving a perpetrator outside the immediate family and being female were factors independently associated with prompt disclosure.

Conclusion: A significant number of adult women and men reported experiencing CSA, and most victims attested to either not disclosing or significantly delaying abuse disclosure.

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Clinical Implications

- The high frequency of undisclosed or delayed disclosure underscores the need for health professionals to inquire about past CSA.
- The high rate of revictimization suggests that health professionals should promote self protective skills among CSA survivors.
- Prevention initiatives need to promote prompt disclosure of CSA, especially for boys and victims of abuse by an intrafamilial perpetrator.

Limitations

- The sample is relatively small and precluded the possibility of conducting separate analyses within gender groups.
- Data regarding attributions or feelings of blame associated with the abuse that may impact disclosure patterns were not documented.
- Variables related to disclosure (recipient, nature of the response following disclosure) that may influence subsequent distress were not investigated.

Key Words: *sexual abuse, disclosure, psychological distress*

In past years, numerous CSA programs have been implemented in schools.[1] One of the main messages is to encourage victims to promptly disclose the abuse to a trusted adult to prevent further abuse. Disclosure of CSA is likely to be followed with numerous interventions from judiciary, medical, and treatment settings to address resulting symptoms.[2] As such, it would be plausible to expect disclosure of CSA to be associated with better long-term outcomes. However, empirical data have not found disclosure to be a reliable predictor of long-term outcomes as no clear-cut relation between telling someone about the abuse and psychological distress can be derived from current empirical studies[2–4] underlying the need for further investigation in this area. In addition, data regarding disclosure rates are scarce[5] and few studies have explored factors related to prompt disclosure in representative samples. Published studies have often relied exclusively on women's experience of CSA. Our study aims to explore disclosure patterns of CSA victims in a representative sample of both adult women and men in Quebec.

Method

Participants

Data were collected by a telephone survey with a sample of adults ($n = 1002$) from Quebec. Selection without substitution was performed in 2 steps. First, households with telephones were selected by random digit dialing. Then, in each selected household, a respondent aged 18 years or older and able to complete the survey in either French or English was chosen using a random selection schedule with no substitution of respondent allowed. The overall response rate was 30%, considering refusals, incomplete interviews, and selected households that remained impossible to reach after 5 attempts on different days and times.

Data from respondents ($n = 1002$) were weighted by region, age, and sex based on the 2001 Canadian census data of adults aged 18 years and older.[6] A correction for design effect was applied. Design effect is equal to 1/(1 + variance of weighted coefficients) and each weighted coefficient was multiplied by 0.81 (or 1/1.24) to correct for the weighting effect on statistical accuracy.[7] This weighting and correction for design effect reduces disparities between characteristics of the sample and those of the population, prevents overestimating, and supports statistical precision. Analyses were performed with this representative sample of adults ($n = 804$). The telephone survey was conducted in April and May 2006 by an established survey firm. Verbal consent of respondents was solicited and our study received approval from the Internal Review Board of the University of Sherbrooke.

Abbreviations used in this article

CSA	child sexual abuse
PC PTSD	Primary Care PTSD Screen
PTSD	posttraumatic stress disorder

Measures

Two indicators of CSA were used: unwanted sexual touching and unwanted sexual intercourse before the age of 18 years.[8] Respondents indicated if any of these experiences ever happened to them and the identity of the perpetrator: a member of the immediate family (for example, father, stepfather, brother), a member of the extended family (for example, grandfather, uncle, cousin), a known but unrelated person (for example, friend of the family, neighbour, teacher), and an unknown perpetrator. Participants were asked their age during the first abusive episode, whether they ever disclosed the abuse, and the delay between the first episode and the disclosure, and any sexual revictimization (another episode of sexual abuse involving a different perpetrator).

The brief French version of the Psychological Distress Scale of the Quebec Health Survey[9] (translation of the Psychiatric Symptom Index[10,11]) was used to obtain a measure of psychological distress symptoms in the week prior to evaluation. Each item is coded on a 4-point Likert scale, from 0 (never) to 3 (very often), with higher scores indicating increased severity of distress. Normative values (80th percentile) are available for a noninstitutionalized Quebec population by sex and age[12] and were used to define clinical levels of distress.

The PC-PTSD[13] is intended to reflect the 4 factors specific to the PTSD construct: reexperiencing, numbing, avoidance, and hyperarousal.[14–16] A positive response to the screen indicates that the respondent may have PTSD or trauma-related problems and that further investigation by a mental health professional may be warranted. A cut-off score of 2 is recommended to optimize sensitivity or to detect positive cases.[13] PC-PTSD scores are highly correlated with scores derived from a structured clinical interview (Clinician Administered PTSD Scale).

Results

Prevalence of CSA

In our sample, 21.4% of women and 9.5% of men reported unwanted sexual activities involving touching by an adult or a child 3 years older than them, and 5.2% of women and 2.3% of men reported rape, for an overall CSA prevalence of 22.1% of women and 9.7% of men (Table 1). Both unwanted touching ($n = 797$, $\chi^2 = 21.43$, $df = 1$, $P < 0.001$) and rape ($n = 800$, $\chi^2 = 4.56$, $df = 1$, $P < 0.05$) were reported more frequently by women, compared with men. Nearly one-fifth of

Table 1 Prevalence of CSA, disclosure patterns, and revictimization, %

	Women (n = 411)	Men (n = 393)	Overall sample (n = 804)
Touching	21.4	9.5	15.6
Member of immediate family	27.1	5.4	20.5
Member of extended family	29.4	21.6	27.0
Known person	32.9	45.9	36.9
Unknown person	10.6	27.0	15.6
Age at first episode, years			
<6	21.8	2.8	16.3
6 11	37.9	63.9	45.5
12 18	40.2	33.3	38.2
Rape	5.2	2.3	3.8
Member of immediate family	20.0	44.4	27.6
Member of extended family	15.0	11.1	13.8
Known person	50.0	44.4	48.3
Unknown person	15.0	0.0	10.3
Age at first episode, years			
<6	9.5	0.0	6.7
6 11	19.0	33.3	23.3
12 18	71.4	66.7	70.0
Any CSA	22.1	9.7	16.0
Disclosure of the abuse			
Never	15.7	34.2	21.3
Within 24 hours	20.2	10.5	17.3
Within 1 month	5.6	0.0	3.9
Within 5 years	7.9	10.5	8.7
After more than 5 years	50.6	44.7	48.8
Sexual revictimization	22.2	21.1	21.9

survivors, both men (21.4%) and women (22.2%) reported revictimization (n = 128, χ^2 = 0.21, df = 1, nonsignificant).

Regarding disclosure patterns, almost 1 out of every 5 CSA victims had not disclosed the sexual abuse to anyone prior to the survey, with men more likely not to have told (34.2%) than women (15.7%) (n = 127, χ^2 = 5.43, df = 1, P < 0.05). Overall, 21.2% of victims reported having promptly disclosed the abuse (within a month), while nearly one-half (48.8%) of victims waited 5 years or more following the abuse to tell someone.

Disclosure Patterns and Outcomes

Table 2 shows the mean and standard deviation of the psychological distress and PTSD scales for the nonvictimized group and the abused groups (prompt disclosers [less than 1 month], late disclosers [1 month or more], and nondisclosers). An analysis of variance revealed a significant main effect. Further posthoc analyses, using the Games-Howell statistic to account for unequal n's and lack of homogeneity of variance of scores across groups, indicated that victims of sexual abuse who delayed disclosure obtained scores indicating greater psychological distress (mean difference = 7.11, P < 0.01) and PTSD (mean difference = 0.53, P < 0.01) than adults without a history of CSA. In addition, a marginal effect was found suggesting that adults who never disclosed the abuse displayed higher psychological distress relative to adults without a history of CSA (mean difference = 8.95, P = 0.06).

Chi-square analyses were performed on the percentage of cases reaching clinical levels of psychological distress and PTSD (Table 3) and adjusted standardized residuals are presented (values greater than 1.96 flag observed values

Table 2 Means (SD) of psychological distress and PTSD scores by groups

	No CSA (n = 673)	CSA promptly disclosed (n = 27)	Delayed disclosure of CSA (n = 74)	CSA not disclosed (n = 27)	F
Psychological distress	10.42 (11.57)	12.49 (8.37)	17.53 (17.29)	19.37 (17.32)	11.26[a]
PTSD	0.34 (0.79)	0.51 (0.82)	0.87 (1.28)	0.95 (1.32)	11.93[a]

[a] df = 3,800; P < 0.001

Table 3 Percentage (adjusted residuals) of participants reaching clinical levels by groups

	No CSA (n = 673)	CSA promptly disclosed (n = 27)	Delayed disclosure of CSA (n = 74)	CSA not disclosed (n = 27)	χ^2
Psychological distress	10.1% (–3.8)	7.4% (0.7)	25.7% (3.8)	25.9% (2.3)	20.92[a]
PTSD (score 2)	3.3% (–5.8)	7.4% (0.5)	17.8% (5.0)	19.2% (3.2)	38.80[a]

[a] df = 3; P < 0.001

significantly different than expected). In both cases, a significant effect was found and follow-up 2 × 2 chi-square analyses indicate that both victims who did not disclose the abuse (n = 700, $\chi^2 = 6.79$, $df = 1$, $P < 0.01$) and those who delayed the disclosure (n = 747, $\chi^2 = 15.71$, $df = 1$, $P < 0.001$) were more likely to achieve clinical scores of psychological distress, compared with adults without a history of CSA. A similar pattern is evident for the analysis of clinical scores on the PTSD scale ($n = 700$, $\chi^2 = 17.14$, $df = 1$, $P < 0.001$ and $n = 747$, $\chi^2 = 31.07$, $df = 1$, $P < 0.001$). Finally, a higher percentage of adults who delayed disclosure achieved scores reaching clinical levels of psychological distress relative to participants in the prompt disclosure group ($n = 100$, $\chi^2 = 4.01$, $df = 1$, $P < 0.05$).

Variables Related to Prompt Disclosure

A logistic regression analysis was conducted where prompt disclosure served as the dependent variable and severity of abuse (penetration), relation to perpetrator, age of onset, and sex of the victim served as the independent variables while controlling for age of the respondent. Results revealed a significant effect (n = 125, $\chi^2 = 12.54$, $df = 2$, $P < 0.01$). After controlling for other variables, sex ($P < 0.05$) and relation to the perpetrator ($P < 0.05$) were independently predictive of prompt disclosure. Odds ratios indicate that abuse disclosure within 1 month was 6.76 times greater for victims abused by perpetrators outside their immediate family, compared with victims abused by a family member. Moreover, female victims of CSA had 3.76 times greater probability of prompt disclosure, compared with male victims.

Discussion

In our study, 22.1% of women and 9.7% of men reported CSA, rates similar to those in North American community samples.[17] Our data suggest that one-fifth of all adults sexually victimized in childhood had not disclosed the abuse prior to the survey, with men more likely not to have told anyone. Moreover, nearly one-half of the victims who had disclosed waited more than 5 years after the first episode to do so. These results are similar to data provided in a study[18] that focused solely on adult women and highlights the fact that delayed disclosure of CSA is quite frequent. Our results indicate that victims who never disclosed the abuse and those who delayed the disclosure are more likely to achieve clinical level scores of psychological distress and posttraumatic stress, compared with adults without a history of CSA.

In exploring variables predicting prompt disclosure, only 2 variables were found to independently predict rapid disclosure of the abuse: sex of the victim and identity of the perpetrator. Being female was associated with a higher probability of telling promptly. Socialization practices and traditional views of masculinity may contribute to male victims experiencing greater feelings of shame. Male victims may be more likely to blame themselves for not being able to prevent the abuse, which in turn may hinder disclosure.[19] Our results also indicate that sexual abuse involving a perpetrator outside the immediate family was more likely to be promptly disclosed, while abuse by a family member was less likely to be associated with rapid disclosure. This finding is consistent with empirical reports and theory on the family dynamics of

intrafamilial abuse involving secrecy.[18,20,21] Extrafamilial abuse may be easier to disclose as there are fewer potential costs associated with disclosing. On the other hand, intrafamilial sexual abuse may be more likely to be associated with a sense of betrayal as well as major life changes following disclosure.[22] Victims of CSA involving a family member may be more reluctant to disclose and seek help as this may imply a sense of disloyalty toward a member of their own family.[23]

The high frequency of undisclosed or delayed disclosure of CSA found in this Quebec sample underscores the need for health professionals in clinical and counselling settings to inquire about past CSA. Unfortunately health professionals rarely ask adults about the occurrence of CSA, particularly when encountering male clients.[24] Male victims may come less to the attention of health care professionals, thereby reducing their probability of benefiting from adequate referrals for counselling and further intervention.[19]

While this analysis provides pertinent information concerning the disclosure patterns of CSA victims, the study presents limitations. The scope of our findings is limited by the cross-sectional nature of the survey design. In addition, the sampling method by telephone number precluded participation from people who may be especially at risk for CSA, such as homeless or institutionalized adults, and a phone survey may not be fully accurate for the disclosure of past CSA. The survey had a response rate of 30% and it is possible that a larger percentage of respondents would have elicited different findings; thus the results may not be generalizable to the community under study. The results cannot be taken to imply causation as nondisclosure or late disclosure of CSA may be a marker of family dysfunction that may lead to increased risk for symptoms, as well as for not disclosing or delaying disclosure of CSA. It is possible the abuse-related variables (for example, type of acts involved, relation between the victim and the aggressor, or age disparity) may influence outcomes. Future studies with larger samples are needed to explore these issues more systematically.

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Résumé : La prévalence de l'abus sexuel dans l'enfance et le moment de la divulgation dans un échantillon représentatif d'adultes du Québec

Objectif : Notre étude cherchait à examiner les modèles de divulgation de l'abus sexuel dans l'enfance (ASE) dans un échantillon d'hommes et de femmes.

Méthode : Un sondage téléphonique mené auprès d'un échantillon représentatif d'adultes (n = 804) du Québec a évalué la prévalence d'ASE et les modèles de divulgation. Des analyses ont été effectuées pour déterminer si les groupes de divulgation différaient en ce qui a trait à la détresse psychologique et aux symptômes de stress post-traumatique, et une régression logistique a servi à examiner les facteurs associés à une divulgation rapide.

Résultats : La prévalence des ASE était de 22,1 % chez les femmes et de 9,7 % chez les hommes. Environ un survivant sur 5 n'avait jamais divulgué l'abus, les hommes étant plus susceptibles que les femmes de n'avoir jamais rien dit à personne. Seulement 21,2 % des adultes déclaraient une divulgation rapide (moins d'un mois après le premier abus) alors que 57,5 % ont retardé la divulgation (plus de 5 ans après le premier épisode). Les victimes d'ASE qui n'ont jamais divulgué l'abus et celles qui ont retardé la divulgation étaient plus susceptibles d'obtenir des scores de détresse psychologique et de stress post-traumatique atteignant des seuils cliniques, comparativement aux adultes sans antécédents d'ASE. Dans l'analyse multivariée, l'expérience d'un ASE impliquant un agresseur hors de la famille immédiate et être de sexe féminin étaient des facteurs indépendamment associés à une divulgation rapide.

Conclusion : Un nombre significatif d'hommes et de femmes adultes ont déclaré avoir vécu un ASE et la plupart des victimes attestaient soit ne pas l'avoir divulgué, soit avoir significativement retardé la divulgation.

Exhibit H

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DISCLOSURE OF CHILD SEXUAL ABUSE
What Does the Research Tell Us About the Ways That Children Tell?

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The empirical basis for the child sexual abuse accommodation syndrome (CSAAS), a theoretical model that posits that sexually abused children frequently display secrecy, tentative disclosures, and retractions of abuse statements was reviewed. Two data sources were evaluated: retrospective studies of adults' reports of having been abused as children and concurrent or chart-review studies of children undergoing evaluation or treatment for sexual abuse. The evidence indicates that the majority of abused children do not reveal abuse during childhood. However, the evidence fails to support the notion that denials, tentative disclosures, and recantations characterize the disclosure patterns of children with validated histories of sexual abuse. These results are discussed in terms of their implications governing the admissibility of expert testimony on CSAAS.

Although it is widely acknowledged that the sexual assault of children is a major societal concern, it is not known how many children are victims of sexual abuse in the United States (Ceci & Friedman, 2000). There are two major reasons for this lack of data. First, present estimates of the incidence of child sexual abuse (CSA) are primarily based on reports received and validated by child protection agencies. These figures, however, do not reflect the number of unreported cases or the number of cases reported to other types of agencies (e.g., sheriff's offices) and professionals (e.g., mental health diversion programs). Second, the accuracy of diagnosis of CSA is often difficult because definitive medical or physical evidence is lacking or inconclusive in the vast majority of cases (Bays & Chadwick, 1993; Berenson, Heger, & Andrews, 1991), and because there are no gold standard psychological symptoms specific to sexual abuse (Kendall-Tacket, Williams, & Finkelhor, 1993; Poole & Lindsay, 1998; J. M. Wood & Wright, 1995). Given these limitations of medical and psychological evidence, children's statements typically represent the central evidence for judging the occurrence of

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CSA. In making these judgments, professionals must often address the delicate issue concerning how children disclose abuse.

According to some experts, a major problem with relying on children's statements in forensic investigations is that many sexually abused children remain silent about abuse; they may deny that abuse ever occurred, or they may produce a series of disclosures of abuse followed by recantations of these disclosures. In 1983, Roland Summit, a psychiatrist, published a formal description of how sexually abused children disclose abuse. The purpose of this model, termed *child sexual abuse accommodation syndrome* (CSAAS),[1] was to outline for clinicians why child victims of intrafamilial abuse may be reluctant to disclose abuse.[2] Summit's model included five components: (a) secrecy; (b) helplessness; (c) entrapment and accommodation; (d) delayed, conflicted, and unconvincing disclosures; and (e) retraction of disclosure. Summit argued that children who have been sexually abused may respond with self-blame and self-doubt. They may fear the perpetrator and the possible consequences of disclosure. Hence, in order to survive sexual abuse by a trusted family member, children make accommodating efforts to accept the abuse and to keep the abuse secret. Furthermore, according to Summit (1983), when children do reveal their abuse, disclosure will be incremental over time, a process that often includes outright denials and recantations of prior disclosures, and then reinstatements of the abuse. It is important to keep in mind that there are two separate aspects of this model, each with its own components. The first stipulates the psychological consequences of abuse (fear, blame, and accommodation). The second aspect, the focus of this article, stipulates the consequences that these psychological states have on behavior (secrecy, denial, and recantation).

Summit's (1983) model has received much attention and has had a significant impact in the area of child sexual abuse. His 1983 article was rated by professionals as one of particular influence in the area of child sexual abuse (Oates & Donnelly, 1997). The components of his CSAAS model have been endorsed by many clinicians and scholars who continue to base clinical and forensic judgments on its tenets (e.g., Adams, 1994; Browne, 1991; Carnes, 2000; Elias, 1992; Ford, Schindler, & Medway, 2001; Kelley, Brant, & Waterman, 1993; King Mize, Bentley, Helms, Ledbetter, & Neblett, 1995; Leonard, 1996; MacFarlane, 1992; Reichard, 1992; Reiser, 1991; Waterman, Kelly, Oliveri, & McCord, 1993; see also Conte, Sorenson, Fogarty, & Rosa, 1991, for a survey of professionals' beliefs). For example, Browne (1991) stated, "Disclosure is almost always an ongoing process. It may begin with an initial quite dramatic first step, or it may manifest itself as a series of tentative revelations, hints, and explorations" (p. 153). Similarly, Kelley et al. (1993) wrote, "Disclosures are often delayed and gradual" (p. 82). Salter (1995) declared, "The child is viewed as having betrayed the family by telling 'strangers,' and such children are frequently pressured to recant" (p. 231). Salter also stated, "Denial is not a door that victims exit; it is a

[1] A similar model posited by Sgroi (1982), child sexual abuse accommodation (CSAA), provided a checklist of 20 hypothesized behavioral indicators of CSA. MacFarlane and Krebs (1986) also proposed a model of reluctant disclosure, one that they termed "no-maybe-sometimes syndrome."

[2] In 1992, Summit (1992) expanded the model to include victims of extrafamilial abuse.

line that victims walk back and forth many times before moving forward" (Salter, 1995, p. 243).

Today these beliefs are echoed in guidelines for assessment and diagnosis of CSA. For example, Children's Institute International,[3] a California-based child abuse assessment and treatment center that has trained over 40,000 professionals worldwide, recommends training and offers a course on CSAAS for all professionals and paraprofessionals who work with children. Another influential organization, the National Children's Advocacy Center (Carnes, 2000), states in one of its publications, "Forensic evaluation is a process of extended assessment of a child when that child is too frightened or young to be able to fully disclose their experiences on an initial forensic interview" (p. 14). "For many children, abuse disclosure is a process, not an event" (Carnes, 2000, p. 21). "Reluctance is commonplace and difficult to overcome in suspected child sexual abuse cases" (Carnes, 2000, p. 42).

Some professionals have gone as far as suggesting that children who readily disclose abuse should be considered suspect. Rather, only those children who initially deny abuse, then make a sexual abuse allegation, then recant it, and later re-disclose, should be considered reliable cases of sexual abuse. For example, Summit (1983) states, "The more illogical and incredible the initiation scene [of the abuse] might seem to adults, the more likely it is that the child's plaintive description is valid" (p. 183). These beliefs are echoed in the courtroom, as demonstrated in the following examples.

> Finally, the majority of children who are sexually abused underreport the extent and severity of the abuse. If I would have heard about lengthy disclosures with a specific beginning, middle, and end to the story, I would have been less impressed since that type of recounting is not likely with sexually abused children, particularly preschoolers. The two most common types of reports that I hear from a sexually abused child of this age are either flat denials or fragmented segments of an incident. (Expert testimony in *Lillie v. Newcastle City Council,* 2002, p. 42)

In the following, a prosecutor questions his expert witness:

> Q: Doctor, you mentioned earlier that with respect to child victims, it is not unusual that they would fully describe all of the events in your first interview.
> A: No.
> Q: And if they do, is it suspicious to you?
> A: To me, yes. (*People v. Carroll,* 2001, p. 70)

Although Summit (1992) wrote that he did not intend to imply that CSAAS is present in all abused children, or that it should be treated as diagnostic of abuse, many professionals have adopted CSAAS as a template by which to diagnose sexual abuse (Fisher, 1995; Kovera & Borgida, 1998; Robin, 1991; Summit, 1992). Perhaps the best example of this practice is reflected in *State v. Michaels* (1993). Margaret Kelly Michaels was accused and convicted of 115 counts of sexual abuse involving 20 children from the Wee Care Day Nursery in Maple-

[3]See http://childrensinstitute.org/ for Children's Institute International's description of their contemporary interview training procedures.

wood, New Jersey. Expert testimony was presented at trial by Eileen Treacy, who stated that children in the case showed behavior consistent with CSAAS and thus their testimony and conduct was consistent with CSA. After 5 years in prison, Michaels' conviction was overturned for reasons including the inadmissibility of testimony that uses CSAAS as a tool to diagnose abuse.

In keeping with the legal rule of excluding expert testimony that seeks to tell the jury to believe a witness (i.e., that the child witness is being truthful, or in general that children are truthful), the courts have uniformly excluded CSAAS evidence that is used to persuade the jury that a child's testimony about sexual abuse is truthful or diagnostic of abuse (e.g., *People v. Duell,* 1990; *Snowden v. Singletary,* 1998; *State v. Gokey,* 1990; *State v. JQ,* 1993; *State v. Jones,* 1993; *State v. Myers,* 1984; see also Freckelton, 1997, for a review of New Zealand and Australian rulings). When a child's inconsistency has been the subject of an attack on credibility during cross-examination, however, most courts have assumed that CSAAS rests on a reliable scientific foundation and have permitted the prosecution to introduce evidence of CSAAS to explain "what would be expected of, or what would be consistent with, facts surrounding other victims of childhood sexual abuse" (*State v. Huntington,* 1998, p. 698).

Given the widespread appeal and currency of CSAAS in the mental health community and its acceptance in the forensic arena, especially when used to rehabilitate an inconsistent child witness on redirect, it is important to examine the empirical basis for this syndrome. In his original article, Summit (1983) stated that the CSAAS model was based on an empirical foundation:

> This study draws in part from statistically validated assumptions regarding prevalence, age, relationships and role characteristics of child sexual abuse and in part from correlations and observations that have emerged as self-evident within an extended network of child abuse treatment programs and self-help organizations. (Summit, 1983, p. 180)

Despite this claim, however, Summit's (1983) article contained no data and seemed to be predicated solely on clinical intuition. Almost a decade later, Summit (1992) clarified, "It should be understood without apology that the CSAAS is a clinical opinion, not a scientific instrument" (p. 156).

In the rest of this article, we review and evaluate the existing empirical data to assess the scientific support for the behavioral components of CSAAS—secrecy/silence, denial, and recantation. We draw on two major sources of empirical data on children's disclosure patterns, each with its own limitations: (a) retrospective accounts from adults who claimed to have been abused as children and (b) examinations of children undergoing sexual abuse evaluations. To foreshadow the results of this review, we conclude that although a substantial proportion of children delay reporting or altogether fail to report incidents of CSA (the secrecy stage), there is little evidence to suggest that denials, recantations, and re-disclosures are typical when abused children are directly asked about abuse. As is seen later in the present article, this emerges as an important distinction on both scientific and applied grounds.

Patterns of Disclosure Among Adults in Retrospective Surveys

Disclosure Rates

The studies discussed in this section include those in which adults with self-reported histories of CSA were asked in a survey whether and at what age they first disclosed their abuse. Table 1 lists 11 studies that yielded rates of childhood disclosure of CSA. Studies that did not provide relevant statistics are not listed in the table but are cited when relevant for related topics (e.g., predictors of disclosure patterns). Finally, we focused on studies that were conducted since 1990 in order to control for cohort effects; in other words, the rates obtained in older studies might reflect practices of several decades ago that are no longer current because of changes in education, advocacy, increased sensitivity, and legal procedures.

As shown in Table 1, the modal childhood disclosure rate (in 6 of the 11 studies) is just over 33%. Three other studies (7, 8, 9) reported slightly higher rates of disclosure that are still low and are consistent with the claims of the CSAAS model that nondisclosure of sexual abuse (silence) in childhood is very common. The disclosure rate of 87% reported by Fergusson, Lynskey, and Horwood (1996) is much higher than those found in other studies, an issue to which we later return. In summary, these data indicate that two thirds of adults who claimed in retrospective surveys to have been abused as children reported that they did not disclose the abuse during childhood.

Disclosure rates were similar for studies that specifically recruited adults with childhood histories of CSA (see Table 1; Studies 3, 4, 5, 8, and 9) and for studies that recruited adults from the general population (Studies 1, 2, 6, and 10). For example, Somer and Szwarcberg (2001) questioned 41 Israeli women who reported that they were sexually abused as children and who at the time of the interview were attending rape crisis centers. (It is unclear whether the women were seeking treatment at the centers for the childhood abuse incident or for some more recent incident.) Less than half (45%) reported that they had disclosed abuse by age 17, and the average delay between abuse onset and disclosure was 15 years. Lamb and Edgar-Smith (1994) questioned 48 women and 12 men who responded to a city newspaper advertisement seeking research participants who had been sexually assaulted during childhood. Although a high proportion of these respondents reported severe intrafamilial abuse, only 36% of the participants disclosed the abuse during childhood (defined in this study as before age 14). The same childhood disclosure rate of 36% was obtained from a sample of women who reported sexual abuse by a relative before the age of 16 (Roesler & Wind, 1994). In another study (Roesler, 1994), 37% of adults with childhood histories of abuse involving genital contact disclosed abuse during childhood. Finally, a slightly higher rate of childhood disclosure was obtained in Ussher and Dewberry's (1995) survey of 775 women who responded to a questionnaire published in a women's magazine. Approximately 54% of these participants disclosed CSA during childhood. These women reported a range of abuse severity, from unwanted sexual attention to severe and repeated abuse from family members. The mean age at disclosure for this group was 26 years, 12 years after the average time when the abuse had ended.

Table 1
Childhood Disclosures of Sexual Abuse: Retrospective Studies

Study	*n*	Sample source[a]	Definition of CSA	Reports abuse at survey	Childhood disclosure	Report to authorities	Avg. age at time of abuse (yrs.)	Avg. age of sample (yrs.)
1. Arata (1998)	860 (f)	College sample	Unwanted contact before 14 yrs.	24.0%	31% (at time of abuse)	10%	8.50	23
2. Smith et al. (2000)	3,220 (f)	National probability sample	Rape	9.0%	34% (within 6 months of abuse)	12%	10.90	45
3. Roesler & Wind (1994)	286 (f)	CSA hotline callers	Intrafamilial before 16 yrs.	100%	36%		6	41
4. Lamb & Edgar-Smith (1994)	48 (f) 12 (m)	Newspaper ad	Not specified	100%	36% (by age 13)		8.15	30
5. Roesler (1994)	168 (f) 20 (m)	Abuse center	Genital contact before 16 yrs.	100%	37%		<16.00	41
6. Tang (2002)	1,151 (f) 887 (m)	Hong Kong Chinese college students	Unwanted sexual experiences before 18 yrs.	6.0%	38%		11.00	21
7. Finkelhor et al. (1990)	1,481 (f) 1,145 (m)	National probability sample	Before 18 yrs.	27.0% (f) 16.0% (m)	42% within 1 yr. of abuse		9.70	30 39
8. Somer & Szwarcberg (2001)	41 (f)	Israeli abuse center	CSA survivors	100%	45% (by age 17)		7.11	32
9. Ussher & Dewberry (1995)	775 (f)	Magazine survey	Unwanted sexual attention	100%	54%	18%	8.50	38
10. Fergusson et al. (1996)	1,019 (m & f)	New Zealand longitudinal study	Unwanted experience before 16 yrs.	10.0%	87% (by age 18)		<16.00	18
11. Hanson et al. (1999)	4,008 (f)	National probability sample	Nonconsensual penetration assaults before 18 yrs.	8.5%		13%	<18.00	38

Note. CSA = child sexual abuse; Avg. = average; yrs. = years; f = female; m = male.
[a]Unless noted, all studies were conducted in the United States.

One might argue that the rates of childhood disclosure obtained in these five studies may not be reliable population estimates because they were obtained from samples of participants who had to declare before study enrollment that they had been abused as children. Perhaps such procedures draw victims with very late disclosures and exclude those who had disclosed at much earlier ages. Alternatively, it could be argued that these rates underestimate the failure to disclose because those who never told anyone may be less likely to respond to such advertisements. Notwithstanding these competing suggestions, however, similar findings have been obtained in studies that included convenience samples of college students as well as national probability samples that were not selected on the basis of childhood histories. For example, Smith et al. (2000) examined data from a nationally representative telephone survey on women's experiences with trauma and mental health (Resnick, Kilpatrick, Dansky, Saunders, & Best, 1993). In this study, 9% of the women retrospectively reported at least one incident of rape (i.e., vaginal, oral, and/or anal penetration by a penis, finger, or object) prior to their 18th birthday. Approximately 27% of these abused women remembered disclosing the rape to someone within 1 month of the sexual abuse; another 34% said they had disclosed within 6 months of the abuse; an additional 18% were not sure when they had first disclosed the abuse. Thus, a considerable number of women delayed or altogether failed to disclose the childhood rape; 47% waited more than 5 years to report the abuse, and 28% said that they had never told anyone about the incident prior to the telephone interview.

Similar rates of nondisclosure were obtained by Finkelhor, Hotaling, Lewis, and Smith (1990) in their national telephone survey of 2,626 American men and women. In that study, 27% of women and 16% of men reported a history of CSA. Of those with histories of CSA, 42% reported having disclosed abuse within 1 year of the incident, 20% told someone of the event later, and 38% had never told anyone of the abuse prior to the telephone interview. Abused men were more apt than abused women never to have disclosed the abuse (42% vs. 33%).

Low rates of disclosure also characterized two college student samples. Arata (1998) found that 24% of female undergraduate students attending a southeastern university reported unwanted sexual contact before age 14 by someone 5 or more years older. Of those with CSA histories, 31% reported having disclosed the abuse to someone around the time of the abuse. Tang (2002) found that in a sample of Hong Kong Chinese college students who reported abuse, 38% disclosed abuse in childhood.

Only 1 of the 11 studies in Table 1 reported high rates of disclosure. The study was carried out in New Zealand by Fergusson et al. (1996) and involved a longitudinal study of 1,265 children. Sexual abuse was defined broadly in this study, ranging from noncontact activities, such as indecent exposure or lewd suggestions (including experiences with same-aged peers), to rape before age 16. At 18 years old, 87% of the abused subsample reported having told someone about the abuse. There are several factors that may account for Fergusson et al.'s finding of high disclosure rates relative to the other studies. As the authors noted, such high rates of disclosure may partially reflect the young age of the adults in their sample: possibly some were still denying the abuse, thus producing lower rates of CSA with concomitantly inflated rates of disclosure. Another factor that could explain high rates of disclosure is that many of their participants reported

noncontact activities such as lewd suggestions, which reportedly the participants did not consider as incidents of CSA. This could also explain why many of these participants denied abuse history 3 years later, during a follow-up interview (Fergusson, Horwood, & Woodward, 2000).

In summary, although one study yielded extremely high disclosure rates (Fergusson et al., 1996), the results of the 10 other retrospective studies indicated that only one third of adults who suffered CSA revealed the abuse to anyone during childhood. Given the differences in methodology, definitions of abuse, and sample characteristics, the general consistency of these findings across these studies is noteworthy.

Predictors of Nondisclosure

In addition to providing overall disclosure rates, some studies also examined predictors of disclosure rates. In this section, we examine associations of some of these predictors from data within studies and, when possible, across studies.

Summit's (1983) original model was based on disclosure patterns of children who were victims of familial abuse. Thus, one would expect that such children would be less likely to disclose than children who were abused by nonfamilial perpetrators. The results of two studies (Hanson, Resnick, Saunders, Kilpatrick, & Best, 1999; Smith et al., 2000) are consistent with these claims; CSA disclosure was more likely when the perpetrator was a stranger rather than a family member. Consistent with these findings, Ussher and Dewberry (1995) reported longer delays to disclosure among intra- versus nonfamilial abuse. In contrast to these three supporting studies, five studies failed to find an association between relationship to perpetrator and CSA disclosure (Arata, 1998; Kellogg & Hoffman, 1995; Kellogg & Huston, 1995; Lamb & Edgar-Smith, 1994; Roesler, 1994). These are surprising findings given the fact that Summit (1983) originally constructed his model to account for nondisclosure in the context of intrafamilial abuse.

Age at time of abuse has not been consistently associated with failure to disclose. Although Smith et al. (2000) found that younger victims were more likely to delay disclosure than older child victims, other researchers (e.g., Arata, 1998; Kellogg & Hoffman, 1995) failed to find any relationship between age and delay of disclosure. There is one important caveat to this conclusion. When study participants reported experiencing CSA during adolescence, this was consistently accompanied by high disclosure rates (Everill & Waller, 1995; Kellogg & Hoffman, 1995; Kellogg & Huston, 1995). For example, in the Everill and Waller (1995) study, in which the mean age at time of abuse was 14 years, 69% of this female sample reported having disclosed to a friend, most around the time of the incident. Kellogg and Huston (1995) found that 85% of their sample of young adults (mean current age = 19.5 years, mean age of abuse = 14 years) had also disclosed at some point in the past. In these cases, the most common confidant was another adolescent (Lamb & Edgar-Smith, 1994; Tang, 2002). In contrast, adults reporting that they revealed CSA as school-aged children did so to a parent rather than to a peer (Arata, 1998; Lamb & Edgar-Smith, 1994; Palmer, Brown, Rae-Grant, & Loughlin, 1999; Roesler, 1994; Roesler & Wind, 1994; but see Smith et al., 2000; Somer & Szwarcberg, 2001). These studies, taken together,

imply that disclosure rates may vary as a function of age at CSA onset, which in turn is associated with the availability of a same-aged confidante.

Finally, no systematic relationships have been reported between demographic variables, such as race and ethnicity, and childhood disclosure rates (e.g., Arata, 1998; Hanson et al., 1999; Kellogg & Hoffman, 1995; Kellogg & Huston, 1995; Smith et al., 2000). However, most of the retrospective studies have too little variability in their sample's demographic composition to test for differences. (For discussions on how demographic variables—race and gender—may be related to CSA disclosure, see Fontes, 1993; Kazarian & Kazarian, 1998; Kenny & McEachern, 2000; Levesque, 1994; Toukmanian & Brouwers, 1998.)

We examined the existing data to determine its support for one of the major assumptions of the CSAAS model; that is, disclosure is related to the amount of fear or violence associated with the abuse. According to the model, children do not disclose because they are afraid of the perpetrator who physically coerced or harmed them. In addition, children also do not disclose because they are threatened with consequences of disclosure that involve harm to family members or to the self. On the basis of these assumptions, it is predictable that the more severe or frightening the abuse or the more the child is threatened postabuse, the less likely the child would be to disclose.

In general, the data do not support the hypothesis that disclosure rates are related to severity of abuse. Although Arata (1998) found lower disclosure rates for contact versus noncontact abuse, there was no relationship between disclosure and method of coercion (e.g., threat, gift, curiosity, appeal to authority, or physical force). To further call into question the validity of this assumption of the CSAAS model, most researchers have either found the opposite pattern—that is, higher disclosure rates are associated with incidents that are life threatening and involve physical injury (Hanson et al., 1999; Kellogg & Hoffman, 1995)—or have not found any significant relationship between severity and method of coercion and disclosure (Lamb & Edgar-Smith, 1994; Roesler, 1994; Smith et al., 2000).

Another method to examine the relationship between severity/coercion/physical harm and disclosure is to compare the rates among studies in Table 1 in terms of the types of abuse that were included in the study. Some experimenters defined CSA broadly (i.e., unwanted sexual attention by anyone), and some defined it more narrowly (e.g., forcible penetration). Despite the differences in definitions (excluding the outlier study by Fergusson et al., 1996), disclosure rates reported across studies were very similar. In summary, the data indicate no consistent association between severity or method of coercion and disclosure.

Next, we searched for studies that examined the relationship between threats that were used to secure the child's silence ("Don't tell or else. . . .") and disclosure. The major problem encountered was that the few studies that reported threat data did not stipulate whether the measure of "threat" referred to statements or actions during the commission of the assault to engender physical compliance or to threats used to engender silence (see, e.g., Arata, 1998; Hanson et al., 1999; Roesler, 1994; Smith et al., 2000). This failure to provide operational definitions of threats is problematic on methodological grounds (How did the study participant interpret the question?) and on interpretational grounds (How does the consumer of the literature interpret the statistics?). Hence, the extant retrospective

data are insufficient to examine whether childhood disclosure rates vary as a function of whether the child was threatened to remain silent.

Summary

The results of the retrospective studies make two important contributions to our knowledge about the patterns of children's disclosure of abuse. First, these data, when taken at face value, reveal that approximately 60%–70% of adults do not recall ever disclosing their abuse as children, and only a small minority of participants (10%–18%) recalled that their cases were reported to the authorities (see Table 1, Column 7). Furthermore, to underscore the results of nondisclosure, many of the adults reported that their first disclosure was during the study survey. Thus, the retrospective studies provide evidence to support the assumption that many incidents of CSA go unreported and that the stage of silence in the CSAAS model has a strong empirical foundation. Second, analyses of predictor variables in these retrospective studies provide few insights into the factors associated with disclosure. They do suggest, however, that commonly held assumptions, such as fewer disclosures among more severe cases of CSA, or in cases of intrafamilial abuse, lack empirical support. We must await further data to examine these issues definitively.

There are two limiting aspects, however, of the adult retrospective literature. The first is common to all retrospective studies; namely, the design raises concerns about the accuracy of the informants' reports. Specifically, it is possible that some adults in these retrospective studies had been abused but continued to deny abuse. Such false denials would work to reduce the overall CSA prevalence rates and inflate the disclosure rates. Alternatively, it is possible that some adults in these retrospective studies had not been abused but claimed to have been. Such false allegations would inflate the incidence of CSA and render the data on disclosure nonmeaningful. Finally, some adults may have disclosed abuse in childhood, despite their reports to the contrary. In some cases, participants may have misdated their disclosure, placing it much further from their victimization than was the actual case. In a related vein, they may in fact have told someone but failed to remember having done so. A rich cognitive psychology literature demonstrates the myriad of retrospective biases, even when the events in question are highly emotional (e.g., Freyd, 1996; Neisser, 1997; Read & Lindsay, 1997; Ross, 1989). In their investigation of flashbulb memories, Schooler and colleagues (Schooler, Ambadar, & Bendiksen, 1997; Schooler, Bendiksen, & Ambadar, 1997) coined the term "forgot-it-all-along-effect" to describe the finding that people sometimes inaccurately recall to whom, when, and whether they reported an important life event. Adults' denial of CSA reports that were actually made during childhood would not affect prevalence rates of CSA but would lead to an underestimation of childhood disclosure rates.

A second constraint in the interpretation of the adult retrospective literature is that although the studies indicate that delayed disclosure or silence is common among sexually abused children, these studies are uninformative as to the frequency that abused children deny or recant abuse reports. This is because participants in these retrospective surveys were not asked if as children anyone had ever asked them about abuse, and, if so, what they had replied. Thus, it is not

known whether the high rates of childhood silence reflected the fact that survey participants had never been asked about abuse, or whether it reflected denial to abuse-related questions. In order to examine the probability of this latter outcome, the literature on children's patterns of disclosure must be examined.

Patterns of Disclosure Among Children Treated or Evaluated for Sexual Abuse

In this section, we review studies of disclosure patterns of children who were specifically assessed or treated for sexual abuse. We examine studies that yielded data on (a) delay of disclosure, (b) denial, and (c) recantation. We also searched for studies that reported data on the correlates of delay, denial, and recantation. As with the retrospective studies reported above, we excluded studies published prior to 1990 because of possible cohort effects that could be due to the changes in interviewing practices and prevention programs (for children) that have occurred in the decade of the 1990s.

Delay of Disclosure (Silence)

The results of the studies using child samples echo the adult retrospective finding regarding delay of abuse disclosure; namely, when children do disclose, it often takes them a long time to do so. For example, disclosure rates of children whose cases were referred for prosecution were examined by Goodman et al. (1992) and by Sas and Cunningham (1995). Although 37%–42% of the children had disclosed within 48 hr of the abuse, it took more than 6 months or even 1 year for many of the children to make a disclosure. Even higher rates of delayed disclosure were obtained in Elliott and Briere's (1994) study, in which 75% of children did not disclose CSA within the first year following the abuse, and 18% waited more than 5 years to disclose the abuse. Similarly, Henry (1997) found that, among 89 criminal CSA records, there was an average 2-year delay between abuse and disclosure. Some of the variability in the length of delay in the child studies may reflect the settings in which the data were collected. Shorter periods of delay may show up in surveys of children in criminal trials simply because delayed disclosure cases might be excluded from consideration because of the inherent difficulty in obtaining convictions. Therefore, it may be that cases in the prosecutor's office are unrepresentative of those that never reach the courtroom.

Few of the studies on delay of disclosure examined individual differences. Nonetheless, there are some data on gender differences, suggesting that boys may be more reluctant to disclose than girls (e.g., DeVoe & Faller, 1999; Goodman-Brown, Edelstein, Goodman, Jones, & Gordon, 2003; Gries, Goh, & Cavanaugh, 1996; Sas & Cunningham, 1995; Stroud, Martens, & Barker, 2000; but see DiPietro, Runyan, & Fredrickson, 1997; Keary & Fitzpatrick, 1994, who report null gender findings). However, as Goodman-Brown et al. (2003) discuss, gender differences in disclosure rates may be suppressed by other abuse-related variables associated with gender (e.g., prior disclosure or relationship to perpetrator).

With regard to empirical findings on disclosure and ethnicity or race, Shaw, Lewis, Loeb, Rosado, and Rodriguez (2001) found that Hispanic girls waited longer to disclose (average delay = 19 months) than African American girls (average delay = 9 months). This finding is consistent with the report that African

American children received more maternal support to disclose abuse than did Hispanic children (Rao, DiClemente, & Ponton, 1992). Although it has been suggested that children raised with values typifying Eastern cultures (e.g., collectivist values, preservation of family, etc.) may be more apt to conceal abuse than children raised in Western cultures (e.g., Futa, Hsu, & Hansen, 2001; Rao et al., 1992; Toukmanian & Brouwers, 1998; Wong, 1987), data are needed to address this hypothesis. In short, there are reasons to suspect that members of certain ethnic groups, as well as boys, may face additional and culture-specific barriers to CSA disclosure. However, the studies that have examined children's disclosure patterns to date do not present a coherent canvas of the effects of demographic variables on abuse disclosure.

Some researchers have examined the association of the abuse characteristics and delay of disclosure. At times, when associations between abuse variables and disclosure are reported, the researchers fail to provide adequate operational definitions of the abuse variables. For example, as was the case with the retrospective studies, the data on "threats" are difficult to interpret because researchers do not specify whether threats are defined tactics to gain the child's compliance during the commission of the assault or as tactics to scare the child into not revealing the abuse. When clearly defined data on abuse characteristics do exist, they are sparse and do not consistently support assumptions underlying the CSAAS model. For example, Sas and Cunningham (1995) found that children waited longer to disclose abuse when the perpetrator "groomed" them and established a close relationship than if the perpetrator used force. Some researchers have found that children who are victims of familial abuse tend to delay disclosure longer than those experiencing extrafamilial abuse (Goodman-Brown et al., 2003; Sjöberg & Lindblad, 2002). However, these studies are exceptional because the majority of studies we examined either failed to find such an association or failed to report an association.

As the analyses of Goodman-Brown et al. (2003) demonstrated, the relationship between delayed disclosure and abuse characteristics is mediated by a complex interplay of variables. These researchers found that in a sample of 218 CSA cases referred for prosecution, older children and victims of familial abuse tended to perceive that more negative consequences would result from disclosure, which in turn was associated with the time taken to disclose. Goodman-Brown et al. (2003) also found increased delays among children feeling responsible for the abuse; additionally, older children were more apt than younger children to feel responsible for the abuse. It is clear from the results of this study that future work must focus on a multivariate model that attempts to provide a causal explanation for the timing of disclosure. Note that none of the studies covered in this section addressed issues concerning denial of abuse. These are addressed in the next section.

Rates of Disclosure (Denial)

In this section, we review 16 articles that were published since 1990 that contained statistics on the frequency of denial. These are listed in Table 2, Column 4, in ascending order of disclosures. When relevant, we cite other studies

Table 2
Disclosure and Recantation Rates From Child Clinic Studies

Study	*n*	Age (range)	Disclosing	Recantations	No. SSI citations	Type of interview
Gonzalez et al. (1993)	63	(2–12)	24%	27.0%	9	Therapy
Sorenson & Snow (1991)	116	Mode = 6–9 (3–17)	25%	22.0%	70	Therapy
Lawson & Chaffin (1992)	28	*M* = 7.00	43%		31	Social worker
Carnes et al. (2001)	147	*M* = 6.00 (2–17)	45%		not listed	CSA team
B. Wood et al. (1996)	55	*M* = 5.70 (6–11)	49%		2	CSA team
Bybee & Mowbray (1993)	106	*M* = 5.60 (2–11)	58%	11.0%	5	CPS and therapy records
Cantlon et al. (1996)	1,535	Mode = 4.00 (2–17)	61%		3	CSA team
Gries et al. (1996)	96	*M* = 8.30 (3–17)	64%	15.0%	2	CSA clinic
Stroud et al. (2000)	1,043	*M* = 8.40 (2–18)	65%		1	CSA clinic
Gordon & Jaudes (1996)[a]	141	*M* = 6.40 (3–14)	74[b]		4	CSA team
DiPietro et al. (1997)	179	*M* = 7.50 (1.4–22)	76% (47%)[c]		4	CSA team
Dubowitz et al. (1992)	132	*M* = 6.00 (< 12)	83% (59%)[c]		22	CSA clinic
Elliott & Briere (1994)	399	*M* = 11.03 (8–15)	85% (57%)[c]	9.0%	31	Clinician
DeVoe & Faller (1999)	76	*M* = 6.80 (5–10)	87% (62%)[c]		7	Social worker
Keary & Fitzpatrick (1994)	251	Mode = 6–10	91% (50%)[c]		16	CSA team
Bradley & Wood (1996)	234	*M* = 10.00 (1–18)	96%[c]	4.0%	16	CPS
Faller & Henry (2000)	323	*M* = 11.70 (3–21)		6.5%	1	CPS/police

Note. SSI = Social Sciences Citation Index; CSA = child sexual abuse; CPS = Child Protective Services.
[a]We do not report Gordon and Jaudes's (1996) "recantation" rate because the child was not interviewed under the same clinical watch, but rather the first interview was a brief medical screening. Also, the authors include parents' disclosures (i.e., as historian) in the base rate. [b]This rate is the percentage of children from the total sample disclosing during the investigative interview. The authors do not report the percentage of disclosing during the investigative interview for substantiated cases. [c]Denotes studies based on cases classified as probable abuse cases; the first disclosure rate is that of children classified as substantiated, high probability, and so forth, the second disclosure rate is for all children examined, regardless of classification of abuse likelihood.

that did not provide data on the rate of disclosure in their sample but that do shed light on the correlates of disclosure.

Most of the studies listed in Table 2 involved "chart reviews" of children who were interviewed by child protective services (CPS), mental health, or medical professionals specializing in the assessment and treatment of sexual abuse (see Table 2, Column 7, for the type of assessment in each study). Children presented at these various settings for a variety of reasons that included a prior disclosure to an adult, a suspicion of abuse by an adult or an agency, or the need for a second opinion or more extensive interviewing. Thus, across and within studies, there is often great variability in the methods by which children were interviewed, in the information collected, and in the procedures of diagnosing CSA. Furthermore, in some studies, as is later noted, researchers categorized the children according to the likelihood of abuse (e.g., highly probable, unclear, or not abused); in other studies, only children who met some prespecified criteria for abuse were included; and in still other studies, the certainty of abuse status was not specified. For those studies that categorized children by likelihood of abuse, the rates for substantiated cases are presented first in Column 4 of Table 2.

The pooled mean of disclosures for studies listed in Table 2 is 64% (range = 24%–96%), or the mean of denials is 36%. For reasons discussed below, however, these figures should not be viewed as the best estimate of central tendency. We focus on four factors that account for the enormous between-study variability in disclosure/denial rates in order to highlight methodological and design factors that need to be considered in evaluating the generalizability, validity, and reliability of the findings in Table 2. These factors are age of the child, previous disclosure of abuse, substantiation of abuse, and representativeness of the selected sample. We conclude that when such factors are considered, mean denial rates are quite low when children are explicitly asked about sexual abuse.

Developmental differences. The wide variation in the ages of the children, both within and between studies (see Table 2, Column 3), could account for differences in the rates of disclosure across studies. In order to examine this hypothesis, age–denial associations were examined within studies. Although no significant relationships between age and denial were found in two studies (Bradley & Wood, 1996; DeVoe & Faller, 1999), the more common finding was that school-aged children are more apt than preschoolers to disclose abuse during formal evaluation. For example, B. Wood, Orsak, Murphy, and Cross (1996) found that older children made more credible disclosures of abuse than younger children.[4] Similarly, DiPietro, Runyan, and Fredrickson (1997) found that older children were more likely to disclose than younger children and that children generally became more likely to disclose abuse after age 4. Keary and Fitzpatrick (1994) conducted a chart review of 251 children assessed by a multidisciplinary team at a CSA unit. Only 29% of children younger than 5 years disclosed during the assessment, compared with 51%, 64%, and 67% of 6- to 10-year-olds, 11- to

[4]B. Wood et al. (1996) defined a *credible disclosure* as one that "was adequate for use as evidence in a future legal and/or child protection proceedings" (p. 84). The "not credible" category included cases "where the child did not disclose, denied sexual abuse, refused to cooperate, provided insufficient detail or was not believable" (p. 84). The authors did not cite the number of children falling into each of the not credible subcategories.

15-year-olds, and 16+ years, respectively. And finally, among foster children receiving therapy for suspected CSA, children who disclosed abuse in the first interview were likely to be older ($M = 9.3$ years) than were children who took two sessions to disclose ($M = 5.8$ years) (Gries, Goh, & Cavanaugh, 1996). Thus, it appears that different rates of disclosure/denial will be obtained depending on the age levels of the children in the sample (see also Cantlon, Payne, & Erbaugh, 1996; Sas & Cunningham, 1995). Of course, these rates are only meaningful if all the children in the sample were actually sexually abused—an issue that we address later in this article.

There are several possible explanations to account for these developmental differences in children's abuse disclosures. They could reflect the single influence or combined influences of linguistic, cognitive, and social–emotional factors. Thus, younger children may not have the same linguistic skills to convey their abuse experience, or younger children may not understand the "meaning" of abusive acts and thus fail to make explicit disclosures. Studies that examine the intent of children's disclosing statements provide some data for this developmental hypothesis. These studies show that younger children are more likely to make accidental disclosures, whereas older children are more likely to make purposeful disclosures (Campis, Hebden-Curtis, & DeMaso, 1993; Fontanella, Harrington, & Zuravin, 2000; Nagel, Putnam, Noll, & Trickett, 1997). That is, younger children are more likely to make spontaneous statements about abuse that are not consistent with the topic of conversation or of the ongoing activity (e.g., stating, while watching TV, "Uncle Bob hurt my bottom"). In contrast, older children are more likely to report the abuse to an adult when asked. Although the conclusions are consistent across studies, the ages of the "younger" and "older" children are not the same across studies. Thus, there is no objective age cutoff that can be inferred from the literature.

A second possible explanation for developmental differences in rates of denial is that there may be higher rates of true denials among younger than older children. This hypothesis is based on several interrelated findings. Younger children may be more likely than older children to be brought for assessment because of their caregivers' concerns about behaviors (rather than an abuse disclosure) that often are ambiguous and do not necessarily reflect CSA (see Campis et al., 1993; Fontanella et al., 2000; Levy, Markovic, Kalinowski, Ahart, & Torres, 1995; Nagel et al., 1997). Thus, in any sample there may be a greater proportion of younger nonabused children than of older nonabused children, and the higher denial rates by younger children would then reflect a higher rate of denial that are true negatives. For example, Keary and Fitzpatrick (1994) were less likely to categorize younger children's presentation as diagnostic of CSA compared with that of the older children; in addition, the younger children were less likely to disclose abuse. Unfortunately, these researchers did not present data on age differences in denial rates among older versus younger children who were classified as "founded" by the assessment team.

Although most of the data indicate that younger children may be less likely to disclose than older children, upon closer investigation, there may also be patterns specific to adolescents. At least among cases that reach authorities, children are most likely to reveal the abuse to their primary caregiver (Campis et al., 1992; Faller & Henry, 2000; Fontanella et al., 2000; Gray, 1993; Henry, 1997;

Sas & Cunningham, 1995). However, adolescents may have a greater appreciation of the consequences of disclosing intrafamilial abuse and thus withhold information. It is also possible that they may not readily disclose extrafamilial abuse to family members or to investigators because they feel it is a personal matter, or they have already disclosed to peers, as noted in the retrospective studies reviewed in the first part of this article. Hence, the rate of CSA disclosure to parents and authorities may resemble an inverted U-pattern, with an increase in disclosure as one moves from preschoolers to school-aged children, followed by an apparent decrease as one moves into adolescence. There are, however, few data on disclosure patterns in adolescence, and we must await these before drawing any definite conclusions. In addition, regardless of potential developmental differences in disclosure patterns, it is highly likely (although not yet researched) that different factors account for denial or disclosure at different age levels.

Prior disclosure of abuse predicts disclosure during formal assessment. The studies included in Table 2 focus on children's reports during forensic interviews and psychotherapy. That is, the children in these studies were specifically brought to a clinic, mental health professional, or law enforcement agency either because they had previously made a claim of abuse or because there was a suspicion of abuse that required further investigation. Thus, most of the children in each study had been questioned by someone (e.g., teacher, parent) about abuse prior to the formal interviews or therapy sessions. This fact is important because, as shown in Table 3, the most significant predictor of disclosure in the formal interview is whether the child had disclosed before (e.g., to a parent, a teacher, a CPS worker, etc.). For example, Keary and Fitzpatrick (1994) reported that of the 123 children who had made a prior disclosure, 86% disclosed again during the formal interview; in contrast, only 14% of the 128 children with no prior disclosures disclosed at interview.[5] Similar patterns of results were found by Gries et al. (1996), DiPietro et al. (1997), and DeVoe and Faller (1999).

This pattern of consistency of disclosure is most common in older children. Among children who had disclosed prior to formal assessment, older children were more likely than younger children to disclose again during formal assessment (Keary & Fitzpatrick, 1994; see also Ghetti, Goodman, & Eisen, 2002).

In summary, several studies suggest that once children have made an abuse disclosure, they are likely to maintain their allegations during formal assessments. This finding suggests that if children have already told a professional or a caretaker about an abusive event, then they are likely to repeat the disclosure in a formal investigation. Discrepant cases (in which a child discloses before the formal interview but denies at the time of the formal interview) represent a small minority and may occur most commonly among very young children.

Abuse substantiation. The third and perhaps most important methodological factor that accounts for variation in disclosure patterns across studies concerns the validity of the diagnosis of CSA. In conducting studies of CSA disclosure

[5]When children have made a prior allegation but do not repeat it during a formal investigation, this should not be categorized as a recantation because it is possible that the child's first allegation was incorrect or misinterpreted, and the report during the formal investigation is accurate. In this article, *recantations* are defined as statements that are made to the same assessment team who heard the disclosure.

Table 3
Rates of Disclosure During Forensic Interviews as a Function of Prior Disclosure

Study	% of children disclosing at formal interviews with prior disclosure	% of children disclosing at formal interviews with no prior disclosure
DeVoe & Faller (1999)	74	25
DiPietro et al. (1997)	77	7
Keary & Fitzpatrick (1994)	86	14
Gries et al. (1996)	93	40

patterns, it is of utmost importance to ensure that the group under study had in fact experienced CSA; otherwise, counts of frequency of delay to disclosure, denials, recantations, and restatements are meaningless. That is, children may deny because they in fact never were abused; children may take a long time to disclose because it is only with repeated suggestive interviewing that they will make disclosures that are false; and children may recant in order to correct their prior false disclosures.

In order to address problems of substantiation of abuse, some researchers have classified children in the sample in terms of the likelihood of abuse having occurred. Cases of suspected abuse that meet one or more of the following criteria (depending on the study) are classified as substantiated abuse cases: perpetrator convictions, plea bargains or confessions, medical evidence, other physical evidence, and children's statements. Although the use of such criteria is a good start, it should be noted that there are problems with each. First, the accused may be persuaded to accept a plea bargain because of the stress, financial burden, and uncertain outcome of facing trial. Also, there are some accused who have been falsely convicted despite the absence of direct evidence to prove child abuse, and on appeal, their convictions have been overturned (Ceci & Bruck, 1995). Although this may not be common, it does happen. Next, medical evidence is not always an accurate indicator of abuse. In the statistically rare case in which genital or anal abnormalities are found, similar abnormalities can sometimes be found among nonabused children (Berenson et al., 1991). Finally, in terms of the studies that are included in this article, the children's statements at the time of formal interview are used as indicators of abuse. But this is a circular exercise whereby children who make spontaneous disclosures with much elaboration, for example, are categorized in the "high-certainty" abuse group. The analysis of the disclosure patterns of the high-certainty group indicates that the children disclosed spontaneously and/or with much elaboration (or did not deny).

Notwithstanding these problems with the use of certainty criteria, there must be some reliable basis to categorize the children in studies of CSA disclosure, lest the disclosure rates obtained merely reflect the overall responses of children (abused and nonabused alike) who are assessed for sexual abuse. Keeping these reservations in mind, we now review those studies that have examined disclosure patterns as a function of the certainty of abuse diagnosis. We argue that, with a few exceptions, high disclosure rates characterize those samples that contain sexually abused children with high-certainty diagnoses, and low disclosure rates

are associated with samples for which the diagnoses of abuse are either unknown or questionable. If correct, then this conclusion bypasses the sundry assumptions of models, such as the CSAAS, and in their place posits that children are found to disclose least when their history of sexual abuse is least certain.

Referring to the studies listed in Table 2, the highest disclosure rates (76%–96%) were obtained from those studies that focused on children with high-certainty diagnoses of sexual abuse. Disclosure rates are greatly lowered in these same studies when the data from the unsubstantiated or unclear cases are averaged with the substantiated cases (see data in parentheses in Table 2, Column 4). Thus, although only 62% of DeVoe and Faller's (1999) entire sample of 5- to 10-year-olds disclosed abuse, when only substantiated cases are included, the disclosure rate rises to 87%. The overall rate of disclosure in the Keary and Fitzpatrick (1994) study was 50%; however, when only the substantiated cases are included, the rate was 95%. DiPietro et al. (1997) classified each of the children in their sample who were assessed because of suspicions of CSA as unfounded, possible, probable, or definitive abuse. Rates of disclosure during the first visit increased as a function of abuse certainty, with 7%, 8%, 59%, and 76%, respectively, disclosing. The overall disclosure rate in Dubowitz, Black, and Harrington (1992) was 58%; however, among their cases rated by an interdisciplinary team as holding low to possible likelihood, the disclosure rate was only 19%, compared with the disclosure rate of 83% for the moderate to high likelihood cases. Elliott and Briere (1994) examined the case records of 399 8- to 15-year-olds who were seen at a child sexual assault assessment center. Overall, 57% of the 399 cases disclosed abuse, with 20 of these children later recanting. When only the 248 children who were in the "abused" category were included in the calculation, the rate of disclosure increased to 84%. It is interesting to compare the profiles of these children with the 20% of the sample who were categorized as "unclear." The latter sample all made noncredible disclosures or noncredible denials of abuse. These unclear children were more likely to be referred by a mandated reporter because of a suspicion of abuse, more likely to be male, and more likely to exhibit increased sexual acting-out behavior.

Returning to Table 2, studies that include cases without providing information on their diagnostic certainty (in ascending order, Gordon & Jaudes, 1996; Stroud et al., 2000; Gries et al., 1996) yield disclosure rates (61%–74%) that are lower than those of the studies just discussed. In these studies, there is no other evidence to confirm the abuse status of these children, and hence the disclosure rates of true positive abuse cases are not ascertainable from the data.

Table 2 shows that the lowest rates of disclosure are provided by Sorensen and Snow (1991) and Gonzalez et al. (1993). On the basis of our analysis of the cases included in these studies, we conclude that these low rates reflect the unreliable diagnoses of sexual abuse in these two studies. Because the Sorensen and Snow study is most frequently cited as supporting the notion that sexually abused children deny and recant (see Table 2, Column 6), it is important to carefully review this study and the characteristics of the sample.

Sorensen and Snow (1991) selected 116 cases of confirmed CSA from a larger sample of 633 children who were involved in CSA allegations from 1985 to 1989. Sorensen and Snow reported that 72% of children denied abuse when first questioned by either a parent or an investigative interviewer; only 7% of these

deniers immediately moved into an "active disclosure" stage, which involved detailed, coherent, first-person descriptions of the abuse. Seventy-eight percent moved into a "tentative disclosure" stage, with partial, vague, or vacillating disclosures of sexual abuse. Eventually, 96% of children made an active disclosure.

There are several factors to be considered in interpreting these data. First, the authors do not state the criteria by which they selected the 116 cases out of the larger sample of 633. One needs some reassurance that the disclosure patterns of this group were similar to that of the larger sample, assuming that the larger sample also contained "confirmed" cases. Second, the children in this study were selected from the private psychological practice of the two authors, and most had been in therapy with Dr. Snow. Sorensen and Snow (1991) did not note how long the children were in therapy or what type of therapeutic methods were used to elicit these eventual disclosures, recantations, and re-disclosures. (For example, it is unclear how forensically based these therapeutic interviews were, compared with, say, the use of play therapy, empowerment enactments with dolls and props, visualization exercises, or other techniques that have been shown to reduce a child's report accuracy.) This raises the issue that the reported patterns of disclosure were consequences of the specific therapeutic practices (of the authors) rather than of reflections of the manner in which children disclose abuse under formal interviewing conditions. This raises the hypothesis that many of the children in their sample may not have been abused (see Ceci & Bruck, 1995).

A glimpse of the authors' clinical practices and cases can be gleaned from a review of the social science and legal records. First, in 1990, Snow and Sorensen (1990) published an article entitled "Ritualistic Child Abuse in a Neighborhood Setting," in which ritualistic abuse was defined as repetitive, bizarre sexual, physical, and psychological abuse of children that included supernatural themes and/or religious activities. Of the 575 cases of alleged child abuse in which the authors served as therapists and/or evaluators between 1985 and 1988, 52 were identified as ritualistic child abuse. Of the 52 children, 39 were allegedly abused in a neighborhood setting. In a number of these cases, the children were first brought in for therapy because of allegations of ritualistic abuse by a nonfamily member; during the course of therapy, the children came to make the following types of disclosures:

> Cross-dressing, masks, and costumes (31%) included red and black robes, men's wearing of women's erotic underwear and dresses, clowns and devil's masks, capes, and costumes such as a lion, bear, snake, witch, devil, Darth Vader, vampires, skeleton, and leather loin cloths. The killing of children and infants was identified by six children in four neighborhoods (15%). Thirteen percent of the children said that they had participated in eating flesh. (Snow & Sorensen, 1990, p. 483)

The disclosures resulted in trials and convictions of two adults. One of the cases, *State v. Hadfield* (1990), was successfully appealed. In addition, five adolescents from other neighborhoods were accused, three of whom were acquitted, and two pleaded guilty.

There is a high probability that a number of the children classified as ritually abused were included in Sorensen and Snow's (1991) study, which sampled from

the same but slightly smaller population that was described in their 1990 study. In addition, because the accused in their neighborhood cases either made pleas or were convicted, these cases met criteria for substantiated cases of abuse.

The problem with the inclusion of these types of cases into studies of disclosure patterns is that there is no evidence to support the once popular belief that ritualistic sexual abuse is common (see Nathan & Snedekor, 1995, for examples). Numerous authorities have failed to find any physical evidence to support the many allegations that have been made and that were the basis of many of the multivictim, multiperpetrator criminal trials of the 1980s and early 1990s (e.g., Lanning, 1991). Furthermore, it appears that the large proportion of reported cases of ritualistic abuse can be accounted for by the practices of a small minority of clinicians (Bottoms, Shaver, & Goodman, 1996; Lanning, 1991). Because Sorensen and Snow diagnosed so many "ritually abused" children in their practice, this, by inference, leads to the possibility that these children's allegations were a product of the practices and beliefs of these clinicians. This information would undermine the reliability of the results of the Sorensen and Snow (1991) disclosure study, rendering them scientifically doubtful.

Reviews of the court records for two trials in which patients of Snow testified about allegations of sexual abuse provide support for the view that the children's allegations were associated with biased suggestive interviewing practices:

> Defendant offered several witnesses at trial who described the suggestive and coercive interviewing techniques allegedly utilized by Dr. Snow and one police officer who described how the children in Dr. Snow's care were able to reproduce specific information after he had suggested to Dr. Snow that such information should be presented in their statements. (*State v. Hadfield,* 1990, p. 508)

On the basis of Snow's testimony in *State v. Bullock* (1989), one of the judges in the case concluded,

> Indeed, Dr. Snow herself admitted that she used interrogation procedures that were not intended to sift truth from error. She forthrightly admitted she was not a neutral interviewer; rather she was "an ally for the child", "biased", and not a fact collector like the police. . . . She also testified in effect that there was nothing in her methods that served as a standard for determining the truthfulness of the stories she produced by her interrogation. . . . But since she starts an interrogation with the assumption that abuse occurred, she then proceeds to prove that point. . . . In short, any claim that scientific principles or Dr. Snow's own expertise and experience validated her conclusions and procedures is devastatingly refuted by her own statement, "I didn't believe any of those kids when they told me it didn't happen." (*State v. Bullock,* 1989, p. 175)

Given the nature of the "validated" cases in the Sorensen and Snow (1991) sample, as well as in the apparently biased and suggestive interviewing/therapeutic techniques, the results of the study are uninterpretable. The patterns of disclosure may merely be characteristic of children who come to make false allegations as a result of suggestion. This would explain why these children originally denied having been abused (because they were telling the truth), why they eventually disclosed (because they were pressured into making allegations), and why they recanted (they wanted to restate the truth).

The Gonzalez et al. (1993) study suffers from many of the same problems. These authors examined the disclosure and recantation patterns of 63 children in therapy for sexual and ritualistic abuse in day care facilities. Gonzalez et al.'s source of data was the therapists' retrospective accounts of the behavior they reportedly saw in their child patients. They found that within the first 4 weeks of therapy, 76% of the children had made vague disclosures ("bad things had happened")[6]; that by 8 weeks, 45% of the children had disclosed highly specific terrorizing acts (killing of adults, children, and animals); and that by 20 weeks, 43% of the children had reported aspects of ritualistic abuse (organized cults). However, for the same reasons that apply to the Snow and Sorensen (1990) article, the findings of this study are scientifically problematic. First, the children in this study were from the *McMartin Preschool* case and other cases that arose in the community at the same time. The allegations in this case, which involved claims of ritualistic abuse, arose after multiple highly suggestive interviews with evaluators and therapists (see Nathan & Snedekor, 1995). At the time of their study, the children had been in therapy on average for over 1 year. There was no physical or corroborative evidence of abuse, and the charges in these cases were eventually all dropped. The interviewing methods used by the children's therapists and evaluators have been documented elsewhere (e.g., Garven, Wood, Malpass, & Shaw, 1998), and the scientific evidence now shows that these methods can produce erroneous reports when used in interviews with children. Thus, the patterns of disclosures made by children in the Gonzalez et al. study may represent those of children who make false disclosures as a result of suggestive interviewing practices.

Finally, the results of the Bybee and Mowbray (1993) study may be open to the same criticism as detailed above. The participants in this study were all involved in a Michigan day care case that involved multiple perpetrators. The case eventually resulted in only one conviction, which was overturned on appeal. Compared with the other studies in Table 2, disclosure rates were quite low; of the 106 children, 58% disclosed abuse.

Representativeness of selected sample. In order to examine the rates of disclosure among sexually abused children who are questioned about abuse, the sample in question not only should have substantiated diagnoses of sexual abuse but also should not be selected on the basis of their preinterview disclosure patterns. For example, it would be meaningless to examine disclosure patterns in a sample of children who were selected because they had already disclosed abuse; the results of this type of study would merely indicate the consistency of children's responses across time. Similarly, one would not want to study disclosure rates of children who were selected for study because they had previously denied abuse. The results of the latter type of study would only address the issue of the degree to which deniers disclose sexual abuse with repeated interviewing.

Three studies in Table 2 (Carnes, Nelson-Gardell, Wilson, & Orgassa, 2001; Lawson & Chaffin, 1992; B. Wood et al., 1996) reported the disclosure rates of

[6]We present a disclosure rate of 24% in Table 2 because it seems that 76% of the children merely said that "bad things had happened," thus not making any claims of abuse. But the denial rate could be higher if the remaining 24% clearly denied any wrongdoing.

children who had not disclosed abuse during an initial interview. The Lawson and Chaffin (1992) study is used to illustrate the point because this sample included children with medical substantiations of sexual abuse; thus, the degree of abuse certainty is high in this study. From a sample of over 800 children who tested positive for a sexually transmitted disease (STD) at a large pediatric hospital, cases that met the following criteria were selected: The presenting complaint was solely physical; there was no prior disclosure or suspicion of abuse; the child was older than 3 and premenarcheal. A sample of 28 girls met these criteria; their mean age was 7 years, and most of the children were from minority households without a father. These 28 children and their mothers were called back to the hospital after they tested positive for an STD. During this interview, the mothers were given the diagnosis for the first time and then were interviewed about sexual abuse. Next, their daughters were interviewed by a trained social worker. Only 43% of the girls made an abuse disclosure during this initial interview.[7] This rate, however, is based on a very different population than sampled in other studies, in which children were brought in either because of a suspicion or disclosure of abuse. Rather, in the Lawson and Chaffin study, children were selected because of their medical history and because they had not disclosed abuse. Because it is not known how many of the 800 children in the larger sample had already disclosed abuse, this subgroup of 28 children with no prior disclosure might compose an unusual sample; that is, they may represent the small hard core of children who do not disclose abuse when directly asked. If they are a small minority, then these results are not generalizable to the entire population of children with STDs. In addition, it should be remembered that very few children who have been sexually abused have any physical symptoms or STDs, and thus this sample again is not representative of the CSA population. There is a second factor that is important to consider. In this study, when the children were called back to the hospital, their mothers were first informed of the STD diagnosis of their children. Children whose mothers accepted the possibility of abuse (the parents were labeled as supportive) were more likely to disclose (63% of this group disclosed), compared with children whose parents were not supportive and did not believe their child had been abused (only 17% of these children disclosed). Elliott and Briere (1994) also found a similar pattern of higher disclosure rates for children with supportive mothers. Among children who disclosed abuse in their sample, 78% had supportive mothers, whereas only 40% of nondisclosers had supportive mothers. Thus, differences among studies might reflect the role of parental support, which might be quite low when parents are first confronted with the fact that their children were abused, as was the case in the Lawson and Chaffin study.[8]

B. Wood et al. (1996) examined 55 videotaped interviews of children referred

[7]In a follow-up study, Chaffin, Lawson, Selby, and Wherry (1997) located 5 of these 28 participants. Though not specifically asked about their children's disclosure, four out of five mothers spontaneously mentioned that the child disclosed CSA subsequent to this initial evaluation.

[8]Although many mothers do not support their children's disclosures of abuse, many are supportive, especially if the defendant is an estranged husband or partner rather than a current one. In many studies, the support rate is between 50% and 85% (see Lyon, 1999, notes 238–239, for details).

by CPS to a multidisciplinary assessment center. All 55 children had been interviewed previously by CPS or law enforcement officials and were included in the study because they had not disclosed. Thus, the disclosure rate of 49% in Table 2 is based on the percentage of children disclosing out of these 55 children who had not previously disclosed during police or CPS interviews. Finally, Carnes et al. (2001) reported that their sample of children undergoing extended CSA assessment because of failure to initially disclose represented approximately 10%–15% of the total population presenting for assessment to the clinics in their study. Thus, the results of this study, as well as the results of the B. Wood et al. study, merely indicate the response patterns of children who had previously failed to disclose abuse during an initial assessment. Furthermore, although this is not the case for the Lawson and Chaffin (1992) study, there are no data on the number of children in both the B. Wood et al. and the Carnes study who met acceptable criteria for diagnosis of sexual abuse. Thus, children who did or did not disclose with extra assessment may or may not have been abused.

Recantations. There are fewer studies on recantations than on denials or disclosures of sexual abuse. All but one of eight studies that have examined this issue (see Table 2, Column 5) also included information on disclosure rates. For the one exception, Faller and Henry (2000) examined the recantation rates of children who testified at trial about their sexual abuse. Thus, all these children had made prior disclosures that were judged as credible by the prosecutors' office. Before reviewing the actual data of the studies, it is important to point out that there could be two different interpretations of recantation. The first is that the child is withdrawing a true statement of abuse. The second is that the child is withdrawing a false allegation of abuse. The child's underlying motivation for a statement is unknowable in each study.

The recantation rates of the studies listed in Table 2 range from 4% to 27%. Our analysis of the variability is very similar to that just carried out with respect to the disclosure rates; namely, the highest rates of recantation are obtained for studies that have the least certain diagnoses of sexual abuse. The two studies with the highest recantation rates were those of Gonzalez et al. (1993) and Sorensen and Snow (1991), in which the recantation rates were 27% and 22%, respectively. Because of concerns about the actual abuse status of the children in these studies, one might argue that these recantation rates reflect the number of children who attempt to discredit their own previous false allegations by setting the record straight.[9] (In the Gonzalez et al. [1993] and Sorensen and Snow [1991] studies, these attempts appeared to have failed, however, as the authors of both studies reported that most of the children reinstated their earlier accusations.)

The lowest rates of recantation are obtained from samples that have the most certain diagnoses of sexual abuse (4%: Bradley & Wood, 1996; 6.5%: Faller & Henry, 2000; 9%: Elliott & Briere, 1994). The slightly higher rate of 15% reported by Gries et al. (1996) is difficult to interpret because there is no information on the number of children who were diagnosed as clear or unclear cases of abuse.

[9]There were also issues concerning the validity of the sexually abused sample in Bybee and Mowbray (1993), who reported a much lower recantation rate of 11%. Thus, recantation rates do not necessarily have to be high for doubtful cases.

Although our analysis shows that some children recant sexual abuse, the results of this analysis show that recantation is uncommon among sexually abused children. In fact, it shows just the opposite; that is, only a small percentage of children in these studies recant.

Conclusions

We began this article by describing the popular view that sexually abused children do not readily disclose their abuse and that even when they disclose, they commonly recant such disclosures. Given how frequently these claims are made in the literature (as well as in proffered expert testimony), we sought to examine their scientific basis. A review of retrospective studies showed that most adults with histories of CSA recall that they never told anyone about the abuse during childhood. This pattern confirms the view that failure to disclose is common among sexually abused children. However, these findings do not address the issue of whether children will deny abuse or recant their disclosures when interviewed. In order to examine these issues, it is necessary to study how sexually abused children disclose abuse when asked directly. Because it is difficult if not impossible to obtain accurate information if the first disclosure is made outside a formal setting (e.g., to a parent, friend, or teacher), we have to rely on studies in which children are questioned in formal investigative interviews. We identified 17 studies that contained relevant data and found that, when the analysis focused on children with substantiated diagnoses of abuse and on children who have not been subjected to the potentially suggestive techniques, most children do disclose abuse within the first or second interview. Only a small minority of these children recant their abuse reports. Even if analyses were broadened to include children with less certain CSA diagnoses, in all but two studies, the majority of children disclosed abuse when directly asked, and only a minority of them recanted their previous disclosures.

One of the basic problems in interpreting the literature on children's disclosures of sexual abuse involves the issue of the validity of sexual abuse diagnosis. As we stated above, in many of the cited studies, classification of abuse was often based in part on children's disclosures; consequently, the conclusion that abused children do disclose abuse during formal interviews may be circular. However, there is some evidence that shows that when children are classified as abused on the basis of medical evidence or other nonchild factors (confession, material evidence), most of these children do disclose abuse. For example, in the Elliott and Briere (1994) study, there were 118 children involved in cases with external evidence: 84% of these 118 children at one point disclosed abuse. In Dubowitz et al. (1992), the finding that 83% of children disclosed abuse was based on the calculation of the number of children with medical findings (but see Gordon & Jaudes, 1996).

Although there are a number of studies to address issues of patterns of disclosure, several overriding issues remain to be addressed. These issues focus on the central theme of individual differences in rates of secrecy, denial, and recantation. Specifically, although the data clearly demonstrate that most children who are interviewed about sexual abuse do disclose and do not later recant, there does exist a minority of children who fit the behavioral pattern that is put forth in

the CSAAS model. The outstanding issues thus focus on the characteristics of these children, and whether these children fit the psychological profiles of the CSAAS model. For example, although Summit's (1983) CSAAS model was developed to explain why children may not disclose intrafamilial abuse, there are few data on potential differences in disclosure patterns when the alleged abuse is intrafamilial versus extrafamilial. Next, there needs to be a greater focus on developmental differences in disclosure patterns. In many of the studies we reviewed, children ranged in age from early preschool to late adolescence. Clearly, it is not very informative to provide group means when age ranges are so great. Studies are needed to examine potential developmental trends in loyalty to family and peers, reactions to fear, need for privacy, choice of confidants, and then to relate these factors to disclosure patterns in children of various ages. Another important area concerns the potential role of threats, which plays a central role in the CSAAS model. In this future research venture, it is crucial to distinguish threats that were used to coerce the child into molestation from threats that were used to secure the child's silence. Finally, in most of the studies cited in this article, there was little if any detailed information about how the children were interviewed and the degree to which standardized and validated protocols were used. In future studies, it would be important to compare the disclosure patterns of children interviewed with current standardized interviews (e.g., Hunter, Yuille, & Harvey, 1990; Sternberg, Lamb, Esplin, Orbach, & Hershkowitz, 2002). If these protocols do in fact optimize the elicitation of reliable statements from children, then the disclosure patterns produced by these instruments would provide the most reliable data to test various hypotheses about the disclosure patterns of sexually abused children and to explore the factors that distinguish disclosers from nondisclosers.

The status of the scientific findings of disclosure patterns is of importance, not only for diagnostic and assessment purposes but also for issues regarding the interviewing of children. As mentioned above, the CSAAS has provided a basis for experts to advocate that when children deny abuse when directly asked, then they should be questioned further and even should be questioned suggestively (e.g., Carnes, 2000; Faller & Toth, 1995; MacFarlane & Krebs, 1986). In order for such practices to be empirically grounded, it is important to demonstrate first that children will commonly deny abuse when questioned (thus calling forth the need for special strategies), and, second, that the use of special strategies will lead to accurate reports of abuse. The findings presented in this article address the first issue only. The second issue has been addressed by a multitude of researchers in the past decade (e.g., Ceci & Bruck, 1995; Ghetti & Goodman, 2001; Poole & Lindsay, 2002; J. M. Wood & Garven, 2000). Professionals need to be aware that although suggestive techniques may produce correct reports from otherwise silent children, these same techniques, especially when used by biased interviewers, entail a risk of producing false allegations (e.g., Bruck, Ceci, & Hembrooke, 2002; Poole & Lamb, 1998). Part of the bias may include the notion that when children deny abuse, they must be pursued until they disclose their abuse; however, as we demonstrated in this present article, the need for suggestive interviewing is probably overestimated because denial of sexual abuse to professionals is not as rampant as previously suspected. Our analysis clearly shows that

when children who have been abused are questioned in formal settings, they will usually tell, obviating the need for suggestive questioning strategies.

We have provided a host of studies that fail to support the view that children who are sexually abused most commonly deny abuse and frequently recant disclosures. Nonetheless, we find that the strong and unqualified assertions regarding the frequency of denials and recantations continue and are supported by the most scientifically problematic of the many studies we examined (e.g., Gonzalez et al., 1993; Sorensen & Snow, 1991). For example, in some recent reviews of the literature, we find the following statements: "It is appropriate to tell the jury that accommodation frequently occurs among abused children, in order to disabuse the jury of misconceptions regarding about how children ought to behave" (Lyon, 2002, p. 110); "A review of the research on CSAAS clearly supports the conclusion that a substantial proportion of abused children exhibit accommodation" (Lyon, 2002, p. 132)[10]; "Furthermore, research reveals that disturbing numbers of children deny their sexual victimization even in the face of compelling evidence to the contrary" (Paine & Hansen, 2002, p. 290); and "Investigations of abuse have frequently been impeded when children fail to disclose abuse, deny abuse that has occurred, or recant a prior disclosure" (Paine & Hansen, 2002, p. 272).

Moreover, even when researchers themselves find low rates of denials or recantations, they still maintain that these are consistent with the popular view. For example, although Elliott and Briere (1994) found high rates of disclosure and low rates of recantation, they concluded their article with the following: "Consistent with Sorensen and Snow's (1991) data, the present results suggest that disclosing sexual abuse is more an ongoing process than a single event" (Elliott & Briere, 1994, p. 274).

The courts have a long history of grappling with how to handle expert testimony regarding characteristics of sexually abused children. In most cases, when courts have permitted expert testimony concerning CSAAS, they have not carefully scrutinized its scientific basis. Instead, they have relied on the unsubstantiated assurances of the proffering expert (as exemplified in the above quotations) or the acceptance of CSAAS by other courts (e.g., *State v. Edelman,* 1999). As shown above, this reliance can result in experts providing incorrect opinions. In recognizing that it makes no sense to accept that an assertion is scientifically grounded "just because somebody with a diploma says it is so" (*United States v. Ingham,* 1995, p. 226), *Daubert v. Merrell Dow Pharmaceuticals, Inc*. (1993) and its progeny in the federal and state courts have directed trial judges to assume the role of gatekeeper and, as such, to examine the relevance and reliability of all proffers of expert testimony. In this role, trial judges are directed to consider falsifiability, error rates, publication, peer review, and general acceptance. In other words, the expert testimony must "rest on a reliable foundation . . ." (*Daubert v. Merrell Dow Pharmaceuticals, Inc.,* 1993, p. 2799; see also *General Electric Co. v. Joiner,* 1997). *Daubert* standards hold for scientific as well as nonscientific experts (*Kumho Tire Company Ltd. v. Carmichael,* 1999).

[10]See Lyon, 2002, p. 109, for Lyon's operational definition of child sexual abuse accommodation.

According to these testimonial standards, the only component of the CSAAS that has empirical support is that delay of abuse disclosure is very common. However, the probative value of expert testimony on delayed disclosure, whether for evidentiary or rehabilitative reasons, is undetermined; some evidence suggests that knowledge about delay of disclosure is within the ken of the jury, perhaps therefore obviating the need for expert evidence on the issue of delay. Gray (1993) surveyed a sample of adults from the general public and a sample of jurors regarding whether they agreed that delayed disclosure was common among abused children ranging from 1 (*strongly agree that delay is common*) to 6 (*strongly disagree*). They found that the general public had a mean rating of 2.3, and jurors had a mean rating of 1.7, suggesting that laypeople tend to believe that delayed disclosure is common. Presently, there is insufficient evidence to conclude whether expert testimony on delayed disclosure meets the *Daubert* standard of possessing probative value for jurors.

The research on denial and recantation shows that when directly questioned in a formal setting, only a small percentage of abused children demonstrate these behaviors. In terms of *Daubert's* concern with error rate, our review of the literature revealed that there was high variability in specific behaviors across studies and that in some cases, the reported rates were inaccurate, reflecting methodological flaws of the study. In summary, there is no convincing evidence that CSAAS testimony on denial or recantation provides relevant or reliable assistance to the fact finder to assess allegations of CSA.

Our intention in writing this article was to examine the empirical basis of professional and lay opinions about disclosure patterns of CSA. In so doing, we found that, although there was much support for the silence/secrecy stage of the accommodation syndrome, most of the evidence failed to provide empirical support for the rest of the model. In order to clearly present these conclusions, it was necessary to dissect the methodological sections of each study and to point out major problems when these occurred. It was also our intent to provide the readers with a host of other studies that provided relevant data that were not prone to the same or as many methodological weaknesses. We believe that child abuse professionals should be aware of this information and incorporate it into their clinical practice as well as into their expert courtroom testimony. If the field is to be guided by scientifically validated concepts, then this must be predicated on the literature that comes closest to the standards of science.

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